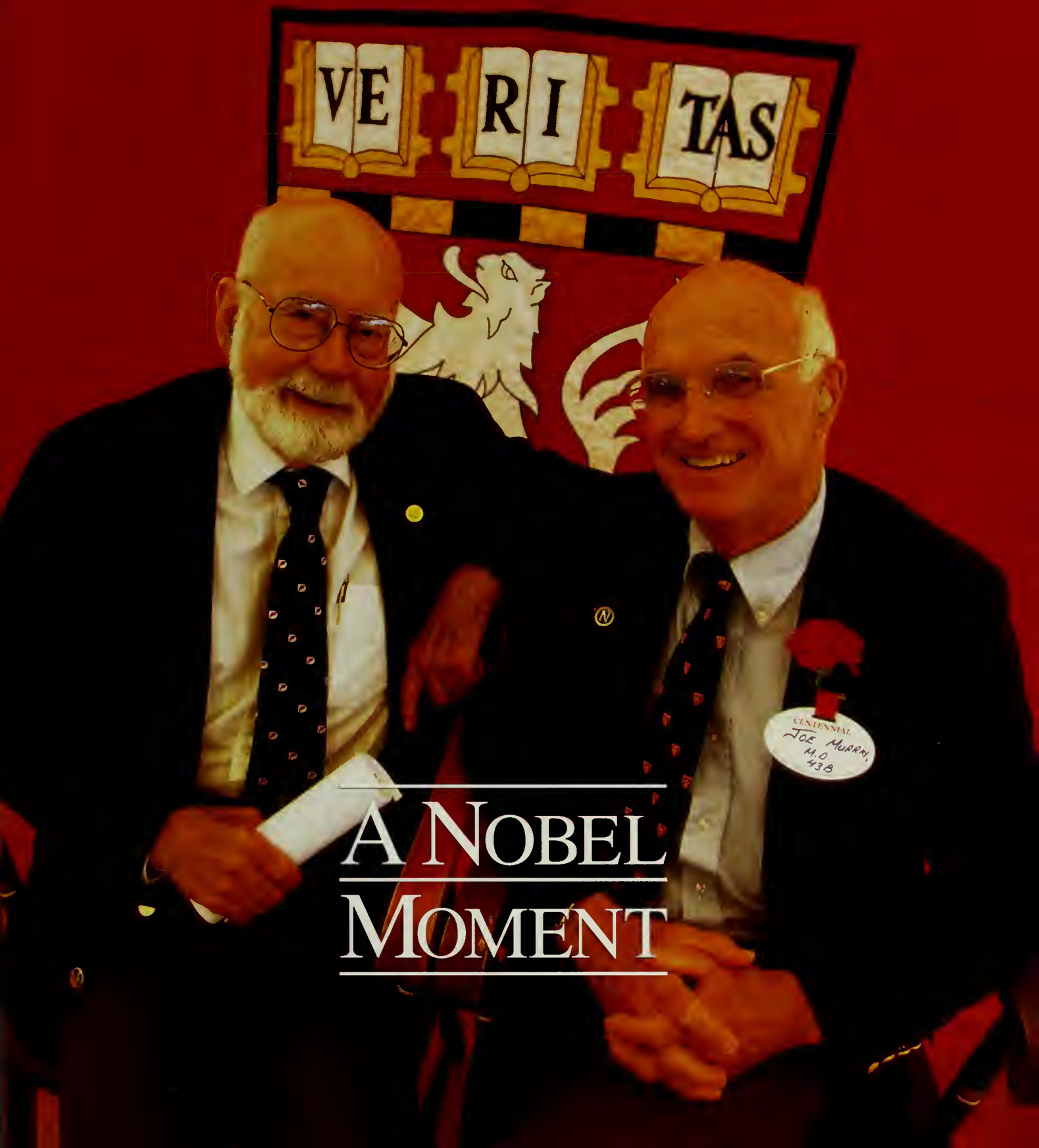
HARVARD MEDICAL

ALUMNI BULLETIN FALL 1991



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ALUMNI BULLETIN / FALL 1991 / VOL. 65 NO. 2

FEATURES

DEPARTMENTS

Cover: In "A Nobel Moment" on Alumni Day, Dean Daniel Tosteson '48 called to the dais Joseph E. Murray '43B and E. Donnall Thomas '46, co-recipients of the 1991 Nobel Prize in Physiology or Medicine. Photo by Jerry Berndt.

INSIDE H.M.A.B.

Alumni Day this year differed from recently established tradition, for this was the Centennial of the Alumni Association. Something special was called for, including a festival banquet!

The morning was given over to a "family" palaver about how alumni feel about their chosen profession. Bob Goldwyn '56 presided. A discussion of the alumni survey report on the subject was followed by discussion from the floor. At high noon Harvard's two present Nobel laureates in medicine, both clinical people, Joseph Murray '43B and E. Donnall Thomas '46, received due tribute from their fellow alumni, making all feel good.

Under the big tent in the warm and pleasant afternoon, Jim Todd '57, executive vice president of the AMA, painted a stimulating picture of the AMA's positive response to the challenge of maldistributed medical care—Health Access America. Jim O'Connell '82 reminded us that the shining of the little candle of compassion and competence are worthy objectives in the care of the homeless. Barry Manuel of BU and Harvey Klein '63 closed the afternoon with a sobering picture of the malpractice insurance morass and the personal devastation that malpractice action may cause. And then the banquet!

The day before Alumni Day came Class Day when, according to recent tradition, the graduating class chose two speakers: Joe Murray '43B, who with characteristic gentle optimism called Browning to his side to prove that "the best is yet to be"; and Jonas Salk, who encouraged the graduating class to meet cheerfully the challenges ahead. Two members of that class responded: David Greenes '91, with an account of how it feels not to know very much—the beginning of wisdom; and Elizabeth Bielgelsen '91, with some sound advice to residents and attending staff on how to teach medical students.

Meanwhile, in nearby amphitheatres, the Class of 1966, the 25th, were amply represented in symposia. One such offering is here recorded: David Scharff '66, with a discussion of reunions of which Robert Benchley would approve. A tripartite discussion of medical ethics led to Mitchell Elkind's (Class of 1992) undergraduate response to the teaching of that subject.

All in all, it was a busy time in the Quadrangle, so beautifully restored that one forgot that beneath us lay a 500-car garage, soon to come to the aid of the faculty.

—J. Gordon Scannell '40

HARVARD MEDICAL
ALUMNI BULLETIN

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ALUMNI COUNCIL: PRESIDENT'S REPORT

Farewell

by Robert M. Goldwyn

This is my final report as president of the Alumni Council, and I wish to take advantage of this space that the *Bulletin* dutifully provides to thank you, the alumni/ae, for the gratifying privilege accorded me. Although the presidency lasts but one year, two years of president-elect precede it. For me, these three years have been an extremely interesting, mind/soul-expanding experience.

Despite the fact that I work within the radius of a Dave Winfield throw to the Quadrangle, I was certainly not conversant with several major problems and preoccupations of the medical school. Now more knowledgeable, I realize that when we, whose daily work is direct patient care, criticize others less clinical for what we consider their myopia or indifference, we should remember that the same condition afflicts us.

Although I might claim some responsibility for the direction and accomplishments of the Alumni Council during my tenure, the timing was right and the soil ready for seeding. That the Alumni Council is never short of talented, committed and imaginative people made my task easier and our objective realizable. Yet none of this would have happened without the backing of Building A.

What have been the most recent accomplishments of the Alumni Council? A major achievement was the polling of alumni/ae about their attitudes toward their careers. This was accomplished by the Alumni Survey Committee, chaired by E. Langdon Burwell '44, in conjunction with Floyd J. Fowler, PhD and Michael P. Massagli, PhD from the Center for Survey Research at the University of Massachusetts/Boston. The Spring 1991 issue of the *Bulletin* contained a resume of the findings, which Fowler presented on Alumni Day (June 7, 1991). Discussion from Burwell and Marilyn Karmason Spritz '53 followed, along with vigorous participation from the audience. This two-way exchange was a highly successful departure from the usual Alumni Day format.

In the afternoon of Alumni Day there were two panels: "Health Care for All," moderated by Barbara J. McNeil '66, with James Todd '57 and James O'Connell '82; and "Redressing the Wounds: Professional Liability and Intrusion of Third Parties into Practice," moderated by Paul J. Davis '63, with Harvey Klein '63 and Barry Manuel, MD, Boston University School of Medicine and former president of the Massachusetts Medical Society. These sessions were an outstanding feature of the centennial celebration of the Harvard Medical Alumni Association.

In that regard, I strongly recommend your reading *In Celebration of Life*, a thorough yet highly readable chronicle of the past 100 years of the Alumni Association, written by Nora N. Nercessian, PhD, associate director of the Alumni Association. (Contact the Alumni Office to obtain a copy.)

Another significant accomplishment of the Alumni Council was the establishment of the Task Force on Medical Student Financing, to be chaired by George M. Bernier Jr. '60, who succeeds me as president and who brings

to this office his experience as dean of the University of Pittsburgh School of Medicine.

A forerunner of the Task Force on Medical Student Financing was the committee concerned with the same issue, under the leadership of Nancy A. Rigotti '78. She and those who served with her were instrumental in bringing to fruition this task force, which will include outstanding representatives from business, banking, medicine and other relevant fields. I should mention that President Bernier wants the alumni/ae to know that he is very strongly committed to the objectives of this task force, and hopes it will find ways of reducing the unrelenting fiscal stresses on medical students.

At its last meeting, the Alumni Council passed a proposal made by George A. Bascom '52 that more practitioners of medicine and surgery be represented on the Alumni Council. The objective is to be certain that the council reflects its constituency and is not overly weighted toward academia. Bascom's idea of giving an annual award to the "Outstanding Practitioner of the Year" is being studied.

In its future meetings, the Alumni Council will consider two other proposals: a survey of students and recent graduates of Harvard Medical School to assess whether their financial indebtedness is a possible determinant of the eventual direction of their medical career: and a survey of alumni/ae to learn what matters they would like to have the Alumni Council consider.

Helping to make this centennial year an enjoyable and instructive one were the efforts of Vice President Nina Tarkoff Rubin '68 and her Centennial Planning Committee.

I wish to thank especially the outgoing council members, whose terms ended in June of this year: George S. Bascom '52, Joseph K. Hurd '64, Barbara J. McNeil '66 and Deborah Prothrow-Stith '79.

I also wish to express my appreciation to all those who ran in this year's election, and I congratulate the winners:

President-elect:
Robert J. Glaster '43

Treasurer:
Mitchel T. Rabkin '55

Second pentad:
Lisa Guay-Woodford '83

Fifth pentad:
George Thibault '69

Ninth and beyond pentads:
Curtis Prout '41

Being president of the Alumni Council involved work, but the pleasure far exceeded the labor. Whatever equanimity I possessed in performing my duties came from the reassuring thought that no matter what my performance, Harvard Medical School would survive. It will continue to pursue the highest standards for the relief of human misery; and perhaps in the next 100 years, it will find ways of preventing much of it. *Vale.*

Robert M. Goldwyn '56 is clinical professor of surgery at HMS, and head of the Division of Plastic Surgery at Beth Israel Hospital.

Editor's Note:

A contributor to our last issue, "Drugs: Friend and Foe," called to our attention his dissatisfaction over our titling of his article. Instead of "The New Big Brother: Mandatory Drug Testing," David Greenblatt '70 would prefer that his article be known by the title "Mandatory Random Drug Testing: Down the Slippery Slope."

LETTERS

Praise and Memories

It was with great pleasure that I read the Spring 1991 issue of the *Bulletin*, particularly the article by Alfred Worcester, who began his medical school studies just 50 years before I started mine. What a contrast between his career and that of world famous William Castle. I had the pleasure of knowing both men, albeit only slightly and under very different circumstances.

Dr. Worcester was 70, a kindly "old" man with some startling ideas, when I, a Harvard College freshman, first met him in 1927.

I wonder how many remember him in his role as Henry K. Oliver Professor of Hygiene (of the college rather than HMS). As freshmen, many of us attended his not-required lectures on hygiene, commonly referred to as "smut talks" because they included subjects such as venereal disease. He ended the series of lectures saying that if any students wanted to discuss further matters of human sexuality, he would be glad to meet groups in their rooms on an informal basis. One of my classmates did in fact arrange such a meeting one evening in his room in Smith Halls.

Dr. Worcester arrived slightly out of breath after three flights of stairs, took off his coat and battered felt hat, sat down and started to talk in a relaxed and affable manner. After a few minutes he said he would start the meeting by asking the dozen or so participants to write down the subjects they would like to discuss.

To avoid any embarrassment, we were to put these slips of paper into his hat, which was passed around the room. When they were collected he gravely picked them out of the hat and seemed to briefly study them—all too briefly for some of us.

"Well," he said. "I see that many of you are concerned about the problem of masturbation." Without further ado, he launched into a full discussion of this subject in a frank and open manner that put all of us at ease. As I remember, the gist of his talk was that it was a perfectly harmless practice that in no way would harm us. He touched on a few other sensitive matters, then he picked up his coat and hat and wished us all a good evening.

This visit of an unusually kind and understanding physician made a lasting impression, which stood me in good stead when I had occasion to deliver the same talk to a diffident young person.

While this tale may seem more than

a little naive to the present generation, in 1927 it was very much to the point.

—Sam Clark '35

Heartiest congratulations for the Spring 1991 issue. I surmise that no HMS graduate could read it without great nostalgia. I particularly enjoyed the comments, tributes to, and anecdotes about Dr. William Castle. My 45 years of relating to medical students at UCSF leads me to believe that most, if not all, of them at some point acquire a faculty or professional "hero," which I suppose in current terminology would be a "role model." Bill Castle was mine for several reasons, one of which can be illustrated by the following anecdote.

My third-year medicine was at the BCH and Dr. Castle was my section leader. I was assigned an elderly lady in severe cardiac failure, with hypertension and a loud murmur indicating aortic regurgitation. Her serology was *positive* but for some reason (almost certainly irrational) I ascribed the etiology of *rheumatic* heart disease and aortic valvular disease and left ventricular failure.

When I presented her to Dr. Castle the following morning, he very properly, but in a characteristically kind manner, exposed my illogical thought processes and conclusions and suggested that a luetic etiology was almost certain.

The patient died that evening and at autopsy the next morning, which we all attended, rheumatic heart disease was the finding. Dr. Castle immediately turned to me and without ostentation and with sincerity said, "You were correct Mr. Adams and I was wrong. Congratulations."

The complete honesty and openness that he showed made an impression on me that has never left, and I think and hope that has directed many teaching relationships with my own students.

—John S. Adams '39

Re: "Learning From the Masters" by Carl Walter, Spring 1991 issue. My memories are like Carl Walter's. I wanted to study medicine and be a surgeon but I had no financial help.

Carl, Dave Lowen and I were the only ones in our class with a chemistry major in college. For three summers prior to being admitted to the Harvard Medical School, I had a chemistry job with the American Smelting and Refining Co. in their chemistry department in Salt Lake City. I saved enough money for about one year in medical school and I was admitted to the 1928/29 class.

Vanderbilt Hall was too expensive for me, so William (Bill) Rew from Montana and I rented a room at 34 Brook Street in Brookline for $10 a month. We also worked as table waiters at the medical school's dining hall for our meals. Now for my good friend President A. Lawrence Lowell; he would eat his Sunday dinner there and I was assigned to be his table's waiter. Dr. Lowell was a kindly man, and what a pleasure for me to know him.

At the end of our first year some of our class called a meeting with Dr. Worth Hale and President Lowell about some financial aid. President Lowell saw me and said, Russell, why are you here. I said, President Lowell, I am one of the poor ones. Dr. Hale said, didn't you all sign a letter that you had the money for your medical education. Someone said yes, we all did or we wouldn't be here now.

I can still see President Lowell's smile. He said, this meeting will be a short one. You are all going to graduate from the Harvard Medical School. The university will loan you the money you need at 5 percent interest. I paid my interest by giving blood transfusions: $50 a pint.

Years later, when my loan was paid, I sent a letter to President Lowell to thank him and the university.

—J. Russell Smith '32

PULSE

Brenner Named First K. Frank Austen Professor

After a three-year search, Michael Brenner, MD has been named the first K. Frank Austen Professor of Medicine. Brenner is founder and chief of the Laboratory of Immunology at Dana-Farber Cancer Institute and associate rheumatologist and immunologist at Brigham and Women's Hospital. The chair was established in 1983 to honor Austen '54, who is the HMS Theodore B. Bayles Professor of Medicine and chairman of the Department of Rheumatology and Immunology at BWH.

Brenner's research has helped define the workings of the T cell, one of the major components of the immune system. He discovered the gamma-delta T cell receptor, the second known receptor on the T cell. His group has continued to investigate the specificity and role of this new receptor, and has shown that T cells with this gamma-delta receptor predominate in the active lesions of various infectious diseases, such as those produced by mycobacteria and certain parasites.

Brenner plans to expand his research on T cell receptors. "I'm enthusiastic about this appointment because it provides the resources to develop a comprehensive program in lymphocyte biology. I would also like to help translate some of our basic research on T cells into advances with

K. Frank Austen '54 and Michael Brenner

Before, During, and After

Views of the Quadrangle during construction and afterwards.

Over the past year, a 500-space parking garage was being built beneath the lawn.

In its "new" form, the Quad has been restored to its original landscaping, as designed in 1908 by the Olmsted Brothers.

PHOTOS BY HUTCHINS PHOTOGRAPHY, INC.

ultimate relevance for diseases such as rheumatoid arthritis and systemic lupus erythematosus."

For Austen, "This professorship has profound personal significance because both my brother Gerald [HMS Edward D. Churchill Professor and chief of surgery at MGH] and I have spent our entire medical careers at HMS, first as medical students, then as house staff, and finally as faculty members. But the chair is certainly one of the capstones of my career."

Austen established an immunology program at the Robert Breck Brigham Hospital in 1966 at a time when the discipline was not well recognized, but was rapidly evolving. From this division with only three full-time faculty members, Austen has gradually developed a department of immunology and rheumatology at the Brigham and Women's Hospital and HMS that now has 60 faculty members and 30 postdoctoral fellows. Austen has also made major research contributions toward understanding host inflammatory responses with a particular focus on the mast cell, the eosinophil, the 5-lipoxygenase pathway to leukotriene generation, and the alternate complement system.

Faculty Honored

Two Harvard Medical School faculty have been recognized for their distinguished and continuing achievements in research by being elected to the National Academy of Sciences: John Collier, Maude and Lillian Presley Professor of Microbiology and Molecular Genetics, and Stuart Orkin '71, Leland Fikes Professor of Pediatric Medicine.

The Academy advises the federal government in matters of science and technology, and to be elected is considered one of the highest honors a U.S. scientist can receive.

In addition, five faculty were elected to the Institute of Medicine, which enlists distinguished medical professionals and others to study health policy issues. The new members are K. Frank Austen '54, Theodore Bevier Bayles Professor of Medicine; Harold Amos, Maude and Lillian Presley Professor of Microbiology and Molecular Genetics *Emeritus;* Patricia Donahoe, professor of surgery; John Kirkpatrick Jr, professor of radiology; and Fred Rosen, James L. Gamble Professor of Pediatrics.

Top Teachers

Harvard Medical School students and faculty honored a variety of outstanding teachers this year.

Mark Peppercorn '69 was chosen for the S. Robert Stone Award, given to an HMS faculty member on the staff of Beth Israel Hospital. Peppercorn, associate professor of medicine, was cited for his profound influence over students in the third-year Core Clerkship, and in pathophysiology.

Assistant clinical professor Joseph Gryboski received the second annual Leo A. Blacklow Teaching Award, given to a Mount Auburn Hospital physician on the HMS faculty. As one colleague expressed it, Gryboski has set "gold standards for generations of medical students and house officers."

The Faculty Prizes for Excellence in Teaching went to Donald O'Hara, William Bennett '68, Alfred Margulies '74 and David Miller. Donald O'Hara, research associate in medicine at Brigham and Women's Hospital, was cited for his contribution to HMS's first-year curriculum, particularly in biochemistry.

William Bennett, lecturer on medicine and editor of *The Harvard Health Letter*, received the second-year

HMS teaching awardees: Back, David Miller (left) and Alfred Margulies '74. Front, Joseph Gryboski (left) and Donald O'Hara.

Mark Peppercorn '68

PHOTOS BY BARBARA STEINER

William Bennett '68

teaching award. One student said of him: "Bill truly shaped my first two years of medical school."

Alfred Margulies, assistant professor of psychiatry, received the third-year teaching award. He was honored for his contributions to Cambridge Hospital's clinical and preclinical psychiatry teaching programs for the past eight years. David Miller, associate professor of ophthalmology at BIH, was presented with the award for fourth-year teaching. Said one student, "He leads by magnificent example."

Harvard's New President Visits HMS

"We have to think about ways to integrate and articulate our university-wide goals and mission," said Neil L. Rudenstine, PhD, Harvard University's new president, who before taking office July 1 spoke informally with members of the HMS faculty and the student council on May 23. "We are, in fact, doing a great deal to help society and somehow we're not getting our message across."

Rudenstine, a Renaissance scholar and former provost at Princeton University, said he is thinking of creating a new position of provost at Harvard. This person would "think across the university," helping to link individual schools that are working on similar issues, such as programs in health care or in primary or secondary education. "If we can identify themes that are important to us and that also respond to major needs of society—and there are acute needs out there not being met—it might help to improve the public perception of universities."

PHOTO BY JOHN LAUERMAN

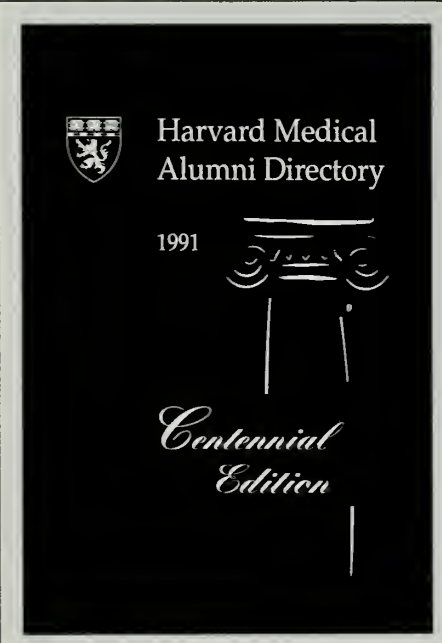
Joel Pomerantz (left) and David Shaywitz at this year's MD/PhD dinner. Seventeen MD/PhD graduates, the largest class in the program's history, were honored at the annual dinner in May. The program is the most competitive in the country, according to director Bernardo Nadal-Ginard, MD. It produces researchers whose work "covers the spectrum of what it means to be in the medical profession," said Dean Daniel Tosteson '48 at the dinner. "It reflects the imagination of the human mind brought to bear on problems relating to human health."

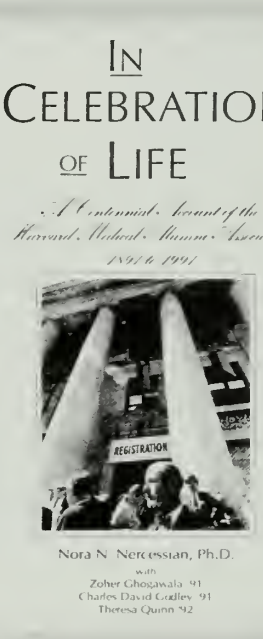
Dean Daniel Tosteson '48 talks with Harvard President-elect Neil Rudenstine.

Rudenstine responded to questions, such as on the undergraduate core curriculum and on financial aid "overlap" —the practice among some universities of agreeing on similar financial aid offers to students. He says he is against the Justice Department's ruling against "overlap," mainly because of what might happen when the system is open to "free bidding." But he emphasized that Harvard would remain committed to need-based financial aid.

He also revealed that he had once thought of becoming a physician. "When I arrived at Princeton as a freshman and said I wanted to be premed, my advisor said I should take intermediate chemistry. I'd never had chemistry and this was not beginning chemistry. I lasted three days. But I have an affinity somewhere deep in my subconscious for what you all do."

Rudenstine graduated from Princeton in 1956, studied at Oxford three years on a Rhodes Scholarship and, after writing a doctoral dissertation on Sir Philip Sidney's poetry, received his PhD from Harvard in 1964.





If you haven't received the 1991 edition of the Harvard Medical Alumni Directory, there are still some available. There are also copies available of In Celebration of Life: A Centennial Account of the Harvard Medical Alumni Association 1891-1991. *Call or write the Alumni Office (617/432-1560), HMS, 25 Shattuck St., Boston, MA 02115.*

CAMPAIGN REPORT

Campaign Capsules

■ In 1990 David Mahoney of New York established the Harvard Mahoney Neuroscience Institute at Harvard Medical School. The mission of the institute is to broaden the public understanding of scientific discoveries emerging from neuroscience laboratories and to expand the funding support needed to bring discoveries from the laboratory to the bedside.

Mahoney, founder of David Mahoney Ventures and former CEO of Norton Simon Industries, is interested in accelerating the pace of discoveries in the neurosciences, and believes that work currently being done at HMS and elsewhere will soon provide answers to the major health problems that diminish, damage or derange the mind. He believes that by recruiting the finest investigators, providing them with the best intellectual and laboratory environment possible, and educating the public about the promise and achievements of research, support for the neurosciences will become a higher priority for government, corporate and private funders.

Mahoney has begun this task by providing funds for the institute. Symposia were held in New York and Palm Beach, Florida, where Dean Daniel Tosteson '48, Gerald Fischbach, MD and David Potter, PhD spoke on research to unravel the mysteries of Alzheimer's disease and addiction. In Southhampton, Long Island, another event took place, which focused on the subjects depression and memory; speakers included Michael Jenike, MD and Steven Hyman '80.

■ Eppie Lederer, better known as Ann Landers, has established a $1 million fund at HMS to provide scholarships for medical and/or graduate students in need of financial support. Called the Ann Landers Fellowship, it honors Derek Bok, whose 30-year service as president of Harvard University came

to a close on June 30 this year.

Lederer's column is one of the most widely syndicated in the world and reaches an estimated readership of 90 million. Her interest in HMS began in 1967 when, at the suggestion of the late John P. Merrill '42, whom she had met in Vietnam, she joined the medical school's Committee on Resources. She was also a member of the medical school's Visiting Committee for the Board of Overseers for a total of 17 years.

■ On the subject of financial aid, the total gifts received for scholarships and loan funds is closing in on the $16 million financial aid goal of the Campaign for the Third Century of Harvard Medicine. Alumni—many of whom themselves received direct assistance as students at HMS—and friends had contributed $15,056,000 as of June 30, 1991.

This includes the $1 million given by Eppie Lederer and a bequest, also made in fiscal year 1990/91, from the estate of Mary Louise Oakes, valued at $228,817, to create the Milton and Mary Louise Oakes Scholarship Fund.

The Financial Aid Office reports that loan funds are now available to meet the needs of current students. With an excellent repayment record, these funds are replenished and made available again each year. The need for scholarship funds continues to grow, however, along with the cost of medical education. The average debt burden for current graduates is over $47,000. Securing new gifts to reduce dependency on loans remains an important priority of the school.

■ ABC network founder Leonard Goldenson and his wife, Isabelle, have committed $1 million to the medical school to further research on cerebral palsy. Their gift establishes the Leonard and Isabelle Goldenson Research Fellowship in honor of William Berenberg, HMS professor of pediatrics *emeritus*, and chief of the cerebral palsy division at Children's Hospital.

Goldenson—Harvard '27 and Harvard Law School '30—is founder and retired chairman of American Broadcasting Companies (ABC) Inc., and is currently the chairman of the executive committee of Capital Cities/ABC Inc. A fund in his honor was established at HMS in 1982 to advance pediatric research in neuromotor control and diseases related to cerebral palsy.

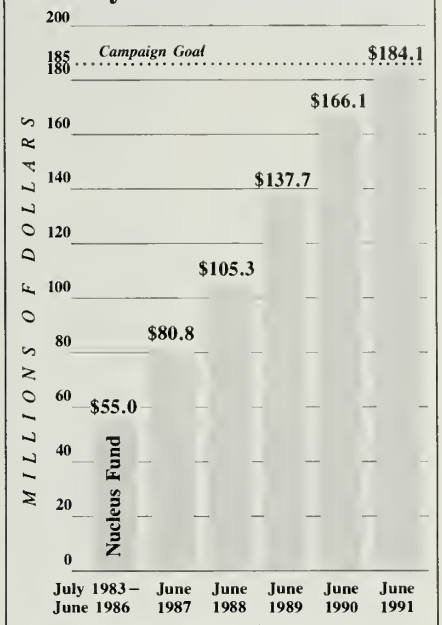
■ The Campaign for the Third Century's Regional Campaign effort has now covered 17 cities and regions across the country. Calling upon fellow alumni, over 500 alumni/ae volunteers have successfully relayed the school's need for unrestricted funds, financial aid, and renovation funds for Vanderbilt Hall.

The just-completed San Francisco-East Bay-Peninsula campaigns were "wonderfully successful," raising over $700,000, to bring the regional campaign total to $4,893,000. Campaigns in Denver, Colorado and Rochester, New York are under way. The total raised through regional alumni campaigns is expected to easily exceed $5,000,000—substantially over the original goal, which is attributable, says Perry J. Culver '41, co-chairman of the National Alumni Fund, "to the wonderful loyalty and support shown by the alumni during this five-year effort."

■ Nobel Prize winner Joseph E. Murray '43B, professor of surgery *emeritus* at HMS, has dealt with his monetary windfall in a way that will surpise no one who knows him. He has used the net proceeds to fund an irrevocable gift for the perpetual benefit of Harvard Medical School in collaboration with two of its affiliated hospitals—Brigham and Women's and Children's hospitals.

Joe Murray's gift is constructed to provide him an annuity for life to help fund his medical and research interests.

Campaign for the Third Century of Harvard Medicine



The Campaign reached $184.1 million in gifts and commitments as of June 30, 1991. The Campaign goal is $185 million.

Thereafter, the principal will be added to the Joseph E. Murray Research Fund for Plastic Surgery. This fund, which could grow into a professorship, is set up to "perpetuate the ingenuity, creativity, courage and fundamental scientific curiosity so characteristic of the fund honoree, Nobel laureate Joseph E. Murray '43B, in his efforts to restore appearance, self-esteem, function and quality of life."

MOBILE RECONNAISSANCE

A Story of Reunion

by David E. Scharff

In September of 1962, 29 years ago, I scurried to Boston, just back from Europe with a young marriage, and an expectant terror at beginning medical school. I found us an apartment whose wood-paneled elegance was pierced by the symphonic screech of the trolleys turning the corner where Commonwealth Avenue bends. And I began a radically altered life course.

On our first day at HMS I became agonizingly convinced that my medical career would be short—perhaps no longer than that day—when my new lab partner, Mahlon DeLong, was unable to calm my panic over my inability to titrate that first organic indicator to any measurable reaction. When I learned of Mahlon's graduate work in physiology, I contemplated the admissions committee's mistake in accepting me, an English major from Yale. They did not know about my sweaty palms and brow, the vagal reaction I experienced at every exposure to blood. That first day of HMS was one of the longest years of my life.

In anatomy, the sweet aroma of formaldehyde surrounded the preserved relics of that most amazing machine in the universe, the human body. But to me, it was a mass of overwhelming data to be learned amidst the stench of death. After all, I had been watching Kent Ravenscroft studying anatomy since high school, when he kept a copy of *Gray's Anatomy* on the back of the toilet for study at odd moments. I was terrified. The hubris involved in beginning here with only the skimpiest pre-med preparation now confronted me. I was more than humbled; I was a quivering mass of protoplasm.

That's my version of the Everyman experience. Some of you must have come with assurance. I have my fantasies about who. And some came with fright like mine. All of us faced our Armageddon then, or have done so since. Some of us may feel we are facing it again today.

Reunions are about such moments. For more than 10 years, I've been something of a reunion junkie. For five years I've pecked away at a book on reunions. I had hoped these reunions would almost speak for themselves; that just setting down the meetings, inquiries and reminiscences would tell the story, just as colors on a flat canvas jump off the page.

They do not. The story of reunion is in the heart and mind, in the vagal responses, of each of us. It is in our reflections of events. Today I feel that my hubris in giving this talk echoes that of our first September day more than half our lifetimes ago. What more do I have to offer today?

I want now to turn to our own responses to reunions and to our own reminiscences. Through these memories we can ask, "Why do we come to these gatherings? What do they mean to us?"

These benchmarks in our lives, these revivals of relationships from our formative youth, are about the specifics. They are about what has happened to Jay Kaufman, Mike Pine, Clem Jurgeleit and the Fletchers. Why did Joan Lamb Ullyot run from the body to the mind? And did John Schott's amazing memory make him rich or famous? And if so, am I envious, admiring or awestruck?

It is inevitable, and is best therefore admitted into evidence, that we come comparing ourselves to our peers. Our competitive selves form a painful underside of our experience. But that is only one side of the larger quest. For it is in redefining each other that we hope to give ourselves more definition, to find and re-find part of ourselves.

When we were together for four years, from 1962 to 1966, we had an investment in each other. We each had those in the class whom we loved, whom we dreaded and whom we hardly knew. There were the loud and prominent members of the class, and the quiet ones. There were those who

PHOTOS COURTESY OF ROBERT LOWN '66

sang, like Scott Nelson and Fred Ilfeld, and those who prayed like Father Ned Cassem. There were those cut out for surgery and those destined for psychiatry. And yet we were, in another way, all of one piece.

Without recognizing it—in all likelihood without willing it, and often enough each of us would have downright disowned it—we belonged to each other! Although I would have been hopeless as an internist, a neurobiologist, a radiotherapist or a medical school dean, I claim an interest—and even more I claim a stake—in the careers of Gil Daniels, Bob Rubin, Jim Mulvihill, David Dale, Mahlon DeLong, Bill Shipley, David Wegman and each of you who have done things I could not have carried off.

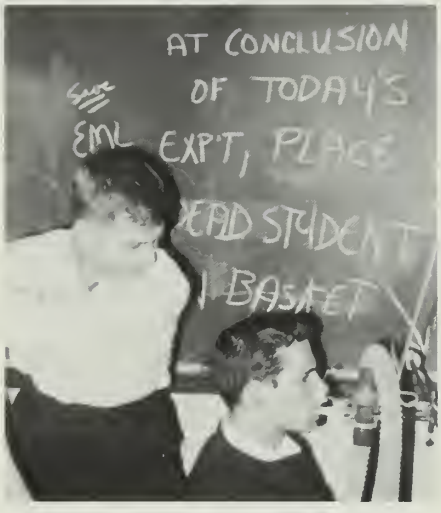
It is really because I could not have carried them off that I want to claim a stake. We shared a beginning, the still undivided trunk of a tree whose branches soon leapt apart and came to intertwine with every aspect of human healing and research. We were there at the beginning, when George Erikson compared us to the primates; when at our first Saturday morning case conference, Franny Moore spared me his question about that woman with advanced and neglected cancer of the breast and directed it instead to my young, pregnant wife, who unwisely had come along because it was a Saturday, a family day. We were there when Eugene Kennedy confused us about the Krebs cycle; when Bernie Davis inspired us about infection, and when David Hubell and Elie Wiesel gave us insight into vision.

With our different capacities, we shared a beginning full of humor, anxiety and excitement. In a universal sense, we had the entire potential of medicine vested in us all—together and undivided. Then we began to branch.

Already in the clinical years we were dispersed. I lost my daily alphabetical intimacy, which had provided security during our first two years of trial by fire while I was sandwiched between the Rs and the Ss—between Robinson, Roglieri, Rothenberg and Rubin on the one side, and by Schoenbaum, Scholand, Schott, Schulman and Shipley on the other. We were enriched by meeting classmates we had not known, including the many of you immigrating from Dartmouth.

But, this enriching experience was already intertwined with loss. Writing this, I remember how those alphabetical groups provided comfort to the worries of my first HMS days. The

Top: *the Class of '66 Second-Year Show; l-r: Fred Finseth, Ted Jacobs, Joel Freidman, Jane Breeden and Bruce Cutler.* Middle: *anatomy lab; l-r: Bruce Cutler, Larry Beck, Fred Steinberg, Al Baker; front: Jay Kaufman and Gene Appel.* Right: *Mark Oren (left) and Scott Nelson in physiology class.*



loss of them has haunted me quietly ever since. I have managed to keep up with only a few of those early friends.

Coming to this reunion offers the hope of finding them again. Indeed, I come now more to count than to compare. Where is Steve Schoenbaum, Les the Dentist, David Wegman, Bruce Brener, with whom I shared an inspiring surgical rotation at the Roxbury V.A.? They are parts of me, and if they are not here, I am the lesser for it.

There are those who have died, whom I mourn. Or often enough, too, I defend myself against mourning by trying not to think about them. But here among you I can say that I try not to think about them because I already missed them when we first branched and began our separate ways. And the pain of their deaths is that of the final loss of opportunity to learn from them, about them, and of the part of my experience—of each of our experiences—they carried: John Asher, Val Donahue, Howard Fox, Bob Siegel, Jay Shumaker, Dean Young. And Jeff Gottlieb, who died in the youth of a distinguished career in cancer research at MD Anderson Hospital in Texas. In this funny way, we all had that in us. Not that each of us could have done what Jeff did, or could have done had he lived. But we were all there, full of

Top: *Sue Fletcher, Monty Bissell and Jane Breeden Marmor at the 25th reunion.* Middle: *Jill and David Scharff, Tom Gettlefinger.* Bottom: *Scott Nelson and Jay Kaufman.*

potential at the beginning. And Jeff carried that for me and for all of us.

As I am saddened by the death of our friends and peers, I am heartened by those of us who have survived. That Tom Gettelfinger, whose early tumor shocked us, survived to have a full life and to run with the best is the kind of thrilling and relieving history that helps us cherish our profession. Against the losses, we can weigh such a recurrently dramatic re-finding.

From Harvard we have made our separate paths, some of us keeping company with a few of our original cohort—those of you in Boston meeting in a recurring pattern. I have said that for me, the reunion represents fundamentally the re-finding of lost aspects of our shared experience—in this way, lost parts of ourselves. But we are searching for these moving targets from the jet plane that life becomes. We, ourselves, are moving all the time.

Our sense of who we are also changes as we cross the spaces of time and age. This moment back together is a search for old experiences and lost parts of ourselves, but we conduct the search as changed and changing persons. We are different now than we were at our earlier reunions. And when we find each other, we will find something different.

Well, the same but different! Shipley is still Shipley. But now he is also a reminder of his father, Professor Shipley—with the twinkle in his eye—whom I first knew when he was not much older than we are now.

Fifteen years ago, we were still the bright, young hope, the promise of future medicine, which we had been in an earlier, unshaped way the day we began HMS. Now we are medicine. We are in it, of it, controlled by it and shaped by it as surely as we shape it. Our time is now. And yet already in our prime, we can see the time when others we helped will have their time.

So how has the phenomena of the jet plane search for ourselves shaped our own meetings? Let me illustrate with moments from three of our previous reunions, hoping you will pardon me the inaccuracies of personal recall.

From our 10th reunion in 1976—15 years ago—I see us at the Saturday clambake at the Dedham Country Club, where Jensie Shipley is demonstrating her wizardry with lobster clippers.

I don't recall much else from that setting. Much clearer in my mind's eye is the cocktail party at Phil and Linda Stubblefield's the first evening. In my memory, none of us is gray-haired or has aged beyond easy recognition. We are alive with a still youthful exuberance, flush with accomplishments, relieved at how little we have changed. We reunite almost as we were then. I see us mid-30s, five years or so out of residency, the military or NIH. There are those of us on the fast track, already accomplished in research, ensconced in Mecca at the MGH, those still without children, and those with a family and career right on track.

In the Stubblefields' old Brookline home, warm with hospitality, we share an urge to reconnect. For me that urge is punctuated by the personal disconnection that divorce brings. I am here, one of the few with a new second marriage, my wife not yet pregnant this time. My friends had known my former wife, Isabel, all through medical school; there is an awkwardness about introducing them to Jill that reminds me of my discomfort when Franny Moore focussed on Isabel 14 years before. Now I feel some pressure in trying to help Jill understand my former life in this brief weekend's kaleidoscope. And I wonder if other couples, together since Harvard, are uncomfortable or sad about my

new marriage.

That 10th reunion experience began me on the path of noting and collecting reunion experiences. Looking back on them, these momentary intimacies tended to slip my memory, so I began taking notes.

Now I have the goods on us from our 15th reunion, 10 years ago. Carl Akins, Gene Appel and Jay Kaufman, as some of you may remember, took the lead in recalling HMS pranks. I believe they were the gang who memorized amino acids, each to taunt Clem Jurgeleit about whether he could repeat the amino acid sequence of insulin.

As I look at us five years ago, I see us becoming more concerned and more tentative; we were grateful already that we had survived, beginning to see the limits of what we could do. We had moved from shared memories of the past to a shared understanding about our present lives.

There were stories at the expense of the women, who on that evening, as so many years earlier, took the first broadside. John Schott claimed that he had once pinched Joan Lamb impishly from behind, and then ducked. She turned and slapped Larry Beck, who ran to the Vanderbilt Hall tennis court and bellowed a challenge to her to a boxing match. Kent Ravenscroft remembered Joan's retort when someone placed an amputated penis in the vagina of her female cadaver. Without missing a beat, Joan called out, "Hey! One of you guys was in a hurry and forgot something."

There were other Larry Beck stories. Like the time when, with George Erikson's help, Larry cracked the code on exam numbers. He knew whose chain to pull when he put up a bogus notice after the anatomy final: "The following students can collect their bone boxes for remedial summer study."

There was Joel Friedman's impersonation of Edward Edwards as Dr. Steady Deadwords, and memories of a Rabelaisian mentor of Scott Nelson's and mine, whose nocturnal sexual adventures were invaded by our need at midnight for his opinion about a patient in crisis.

Sex led the stories of the evening. One of our classmates had shown the famous venereologist Dr. Tolman a penile lesion on an old man, suggesting it was a chancre. Tolman dismissed the diagnosis, replying, "That's nuthin'!"

"Oh yeah?" said the patient. "Let's see yours!"

This story led to memories about the members of our class who had supported the Harvard infertility program and themselves by donating sperm for artificial insemination at the Lying-In Hospital. One classmate told of being interrupted by a maintenance man while trying to produce a sample. As the student left, he heard the man tell his buddies, "Those medical students are at it again! There's one in there playing with himself!"

These jokes were tied to serious concerns, such as Gene Appel telling us that he was occasionally haunted by thoughts of the unknown children he might have produced by those donations. This may have been one of our first shared expressions of what became a prominent theme five years later: what and who will we leave behind?

There were serious conversations too. Charlie Hatem told me about his interest in medical education and Harvard's experimental New Pathway program. Jim Krainin and I discussed our mutual interests in psychiatry. But what dominated the shared experience was the search for youthful hilarity, the gleeful re-finding of our pranks and our medical student humor. Ten years ago we were fortyish. We reveled in our pranks as many in the first throws of mid-life reach, sometimes desperately, for pranks of their own. Gene, Larry, Jay, Joel and Ned beckoned us to remember.

Five years ago we were different. After dinner at the Chatham Bars Inn, we accounted for our books and research, our Vietnam-era experiences —those with Berry Plan draft deferments, Public Health Service draft-evaders like me, and conscientious objectors like Jim Gordon, as well as those who served in Southeast Asia. Wives spoke more because they were not excluded by a fantasy of a return to the med-school experience, which had dominated our anecdotes five years earlier.

At this 20-year reunion, we turned to the future of medicine and of health. Tom Gettlefinger talked about the decline of ophthalmology under the impact of marketing and insurance concerns—an eye for an eye. Mike Rie spoke of the evolution of his interests from anesthesiology to ethics, how issues of conscience arose from his work in the ICU at Mass. General. We shuddered in painful recognition as he said, "Medicine is abdicating its authority in our culture."

And inevitably we asked, "What about the values we had when we came here 24 years ago? Knowing now about these infringements on our work, would we still choose medicine? Would you, or have you, told your children to go into medicine?"

So, we concluded with questions about ourselves as the link between the generations of medicine: can we find this valued part of ourselves in our children?

As I look at us five years ago, I see us becoming more concerned and more tentative; we were grateful already that we had survived, beginning to see the limits of what we could do. We had moved from shared memories of the past to a shared understanding about our present lives. Privately, we discussed painful setbacks and compromises. Publicly, we lamented those not with us. We began to question the legacy we would convey to our children and the world. We took stock of our limits. We celebrated what we had.

Now it's our 25th HMS reunion. Here we are at 50-plus, approximately at mid-career. With what questions and longings do we now meet? We bring accomplishments, missed opportunities, losses. I come back to Boston and to Harvard hoping to re-find the riches of knowing so many of you in different ways, at different times in our shared but often lonely journey. For me, as I hope for each of us, life has already been full of wonders. This reunion is another excursion in life's moving search. This mobile reconnaissance in the middle of our careers is an expedition not to be missed!

David E. Scharff '66 is director, Washington School of Psychiatry; clinical professor of psychiatry, Georgetown University School of Medicine and Uniformed Services University of the Health Services. He works intermittently on a book on the kinds of reunions he has attended.

Class Day

Music by Saint-Saens and Elgar trumpeted from the loudspeaker, signalling the commencement of the last hour that the Class of 1991 would be Harvard Medical students. This class, the first to be entirely integrated into the New Pathway, is also the first to become Harvard Medical alumni in the second century of association.

It was a beauteous sunny day, all the more so because it followed a week of rain. Family and friends of the 161 HMS graduates and 16 HSDM graduates turned out in full force to salute the class's achievements.

After welcoming remarks by class co-moderators Nora Jaskowiak and Stuart Anfang, David S. Greenes '91 got the laughter rolling by comparing what he knows about medicine to "Doogie Howser," the 16-year-old television doctor who is supposedly just starting his residency. "This season alone Doogie has performed an emergent appendectomy, delivered a couple of babies, counseled an alcoholic, and completed a corneal transplant." Greenes then told of how he learned that it was all right not to know everything, and that it's a sign of strength, not weakness, to be able to learn from others.

Beth Biegelsen '91 had advice for fellow graduates who were experiencing "sheer terror" on this momentous occasion: "When Dean Tosteson approaches you with his most congratulatory smile, ready to hand you that diploma, JUST SAY NO!" She described what she learned about how *not* to treat medical students, and concluded that her class had learned a lot these four years about caring for one another and how to be caring. "Maybe our students will learn different lessons. If we can teach them some of what we've taught each other, I know they will."

Joseph E. Murray '43B, HMS inside speaker and 1990 Nobel laureate, recounted what it was like at HMS during the war-torn years, and how he became interested in reconstructive surgery and transplantation biology. He recalled the words of Thoreau: "If one advances confidently in the direction of one's dreams and endeavors to live the life which he (or she) has imagined, he (or she) will meet with a suc-

PHOTOS/M. JERRY BERNDT

cess unimagined in common hours." He told graduates that his life has been blessed beyond his wildest dreams, and quoted from one of his favorite Robert Browning poems: "Grow old along with me/ The best is yet to be/ the last of life for which the first was made."

The keynote speaker was Jonas Salk, MD, developer of the first polio vaccine. He talked about the challenges ahead for this generation, which has a responsibility to set goals and realize visions for a better tomorrow of human health and well-being. He passed on some advice that he was given at a career crossroad after he had finished the initial work on the polio vaccine: "Whatever you choose, do that which makes your heart leap."

In addition to thanking their loved ones in the audience, the Class of 1991 showed their appreciation for faculty and friends. The preclinical teaching award went to Susumu Ito, James Stillman Professor of Comparative Anatomy, and the clinical award to Sanjiv Chopra, assistant professor of medicine. Special awards were presented to Daniel Goodenough, Takeda Professor of Anatomy and Biology and first master of the Oliver Wendell Holmes Society, and to Catherine Keyes of the Office for Student Affairs, who is leaving to start law school.

To celebrate the fact that this was the first entire class to go through the New Pathway, the masters of the academic societies did the "hooding": Walter Abelmann and Roger Mark (co-directors of the HST Division), Ronald Arky (Francis Weld Peabody Society), Robert Colvin (Oliver Wendell Holmes Society), Stephen Krane (Walter Bradford Cannon Society) and Stephen Robinson '58 (William Bosworth Castle Society).

Fourteen students graduated cum laude in a special field, seven graduated magna cum laude, one summa cum laude, and nine were honored with prizes or awards:

Stuart A. Anfang, the Richard C. Cabot Prize for the best paper on medical education or medical history: "To Tell or Not To Tell: Knowledge, Authority and the Medical Profession: An Inquiry into the Evolution of Physicians' Attitudes Towards Disclosure to the Terminally Ill Patient."

David J. Araten, cum laude: "Immune Tolerance in Adult Recipient of Partially MHC Mismatched Bone Marrow Grafts."

Nora Jaskowiak presents a special teaching award to Daniel Goodenough, Takeda Professor of Anatomy.

Neal H. Atebara, magna cum laude: "Image Contrast and the Optics of Multifocal Intraocular Lenses."

Hina W. Chaudhry, cum laude: "Laser Induced Relaxation of Vascular Smooth Muscle."

George Q. Daley, summa cum laude: Leon Reznick Memorial Prize for excellence and accomplishment in research: "Implicating the bcr/abl Gene in the Pathogenesis of Chronic Myelogenous Leukemia."

Robert M. Friedlander, cum laude: "Experimental Angiogenic Modulation of Benign Human Schwann Cell Tumors."

Zoher Ghogawala, magna cum laude: "An Intronic 10 Base Pair Deletion in a Class II Aβ Gene Affects RNA Processing."

Thomas M. Glaser, magna cum laude: "Genetic Linkage Analysis of Mouse Chromosomes 2, 12, and 19."

Andrew S. Kanter, Rose Seegal Prize for the best paper on the relation of the medical profession to the community: "Comprehensive Primary Health Care: A Case-Study in Nepal."

Sam Tzen-yue Hwang, magna cum laude: "Protein Import into Mitochondria: A Novel Intermediate of Protein Translocation Is Located in the Intermembrane Space and the Purification of a Mitochondrial 70 KD Stress Protein."

Victor Khabie, cum laude: "The Revascularization of Healing Flexor Tendons Within the Digital Sheath: A Vascular Injection Study in Dogs."

Stephen O. Kovacs, cum laude: "Worksite Health Promotion in Massachusetts with Emphasis on Physical Fitness Oppor-

Deans Daniel Federman '53 (left) and Daniel Tosteson '48

tunity in the Reduction of Coronary Heart Disease."

Matthew E. Mitchell, cum laude: "A Novel Peptide Activated Cation Channel."

Charles E. Moore, cum laude: "Mechanisms Involved in Central Nervous System Acid-Base Regulation in *Rana catesbiana* During Apneic Diving."

Christopher J.L. Murray, magna cum laude: Henry Asbury Christian Award for notable scholarship in studies or research: "Levels, Patterns, and Causes of Adult Mortality in Developing Countries."

Leo S.K. Paik, cum laude: "Interleukin 1*B*: Analysis of Structural and Functional Relationships."

Elizabeth Ann Rider, Dr. Sirgay Sanger Award for excellence and accomplishment in research, clinical investigation or scholarship in psychiatry: "The Stresses of Graduate Medical Education: A Look at the Problems, Solutions, and the Facts of Family Life."

Maria A. Rupnick, cum laude: "Steroid Regulation of the Vascular Endothelial Cell Plasminogen Activator System."

Marc S. Schwartz, cum laude: "Overexpression of Oncogene Products Can Cause Tumor Progression But Not Parenchymal Infiltration Within the Rat Brain."

Albert Ching-gin Shaw, James Tolbert Shipley Prize for excellence and accomplishment in research: "Mutations of Immunoglobulin Transmembrane and Cytoplasmic Domains: Effects on Intracellular Signaling and Antigen Presentation."

Priscilla Jennings Slanetz, cum laude: "Hemoglobin Blood Substitutes in Preoperative Autologous Blood Donation."

Reisa A. Sperling, cum laude: "Progressive Supranuclear Palsy: A Paradigm of 'Subcortical Dementia'."

Ming Xu Wang, magna cum laude: Harold Lamport Biomedical Research Prize for the best paper reporting original research in the biomedical sciences: "Screening Genomes to Identify and Characterize DNA Sequences Involved in Strong DNA-Protein Interactions."

Mark S. Weinfeld, cum laude: "Cellular Fatty Acid Modification Modulates Hydroxymethl-glutaryl-CoA Reductase and Acyl-CoA: Cholesterol Acyltransferase Activities."

Lisa K. Weiss, cum laude: "Investigation of the Regulation of Troponin T's Alternative Splicing."

The Best Is Yet To Be

by Joseph E. Murray

From earliest memory I wanted to be a surgeon. There were no physicians on either side of my family, my father being a judge and my mother a schoolteacher. As a youth I frequently drove by these marble buildings on Longwood Avenue and just assumed I would end up at medical school here.

In September 1940 I entered Vanderbuilt Hall as a first-year student, and since then each year has been more fulfilling and satisfying than the previous one. So I thank you, the Class of 1991, for inviting me to be your "home" commencement speaker. Sharing with you my 51-year love affair with HMS is another layer on the sumptuous layer cake that the school has concocted.

My only motive for becoming a physician was, and still is, to care for patients. However, at medical school in the early '40s, I quickly realized how meager was the knowledge of the causes and treatment of most of the conditions we were studying. True, vaccines existed for typhoid fever and diphtheria, anti-sera for some pneumonias were available, and excisional surgery for appendicitis and gall bladder disease existed.

But leukemia and subacute bacterial endocarditis were 100 percent fatal. Cardiac surgery and chemotherapy for neoplasm did not exist. The terms immunosuppression, B cells and T cells had not been coined. The function of the thymus gland was unknown. Most treatments were purely for symptoms or palliation. Poliomyelitis was a dread disease that filled the hospital wards with patients in cumbersome traction and physiotherapy devices. Sulfonamides drugs were the contemporary "miracle" drugs; penicillin had not yet appeared.

I was impressed by all the research going on, but as a student my main aim was to graduate. I concentrated on passing the required courses and was somewhat intimidated by classmates who combined research with curricular study. However, assuming that HMS graduates have at least average intelligence and a good medical education, I have noted over the years that satisfaction and productivity in any career—clinical, research or a combination—are 99 percent a result

of enthusiasm, physical and mental stamina, persistence and honesty. My only medical school research was during my fourth year, a project with Arthur Hertig involving the then new Papanicolaou stain.

The attack on Pearl Harbor occurred in the middle of my second year. We were all inducted into military service and completed our courses in an accelerated program; hence two classes graduated in calendar year 1943, '43A in March, '43B in December.

After a war-shortened, nine-month surgical internship at the Peter Bent Brigham Hospital, I was called to active duty and randomly assigned to a plastic surgical army hospital at Valley Forge General Hospital, Pennsylvania to await an overseas assignment. I was young, healthy, unmarried and, with only nine months surgical internship experience, a perfect candidate for an overseas assignment as a battalian surgeon. World War II was still raging, the Battle of the Bulge was ahead, the Rhine River had not been crossed, and casualties from the Pacific, European and African theatres were constantly rolling in.

During my assignment at Valley Forge, where over 3,000 plastic surgical patients were cared for, I took every opportunity to participate in patient care. I loved helping with the dressings of the severe schrapnel and gunshot wounds of the head, trunk and extremities. I marvelled at the recuperative powers of the body as these foul smelling, necrotic wounds were converted to clean, healed surfaces.

Many severely burned patients required daily dressings under anaesthesia, a rather unpleasant task usually assigned to the most junior doctors. I enjoyed doing these dressings, which relieved pain and accelerated healing. Because of this enthusiasm, care for many burn dressings was assigned to me.

Meanwhile several other young, inexperienced surgeons like myself had come to Valley Forge on temporary duty awaiting overseas orders. Most were sent overseas almost immediately, but somehow I never was. I remained at Valley Forge for three years, until November 1947, more than two years after V-J Day. I learned 10 years later from the chief of plastic surgery that he had noted my caring and concern for patients, and had requested that the commander-in-chief of the hospital "freeze" young Lt. Murray for the duration.

Graduates listen to the speakers during Class Day.

The Valley Forge experience decisively molded my surgical career. I found reconstructive surgery more challenging than excisional surgery, i.e., appendectomy, cholecystectomy and gastrectomy. The unpredictability and imaginative aspects of transplanting skin, bone, cartilage and fascia from one part of the body to another were immensely satisfying.

Many extensively burned patients required skin grafts from other persons because of insufficient unburned skin to serve as donor sites. These skin allografts could not survive permanently, but they could be life-saving as temporary skin cover by controlling sepsis and fluid loss.

I still recall my wonder at observing daily the mosaic of autografts and allografts. At first all grafts looked the same—healthy and vascularized. But after a week the autografts would begin to grow and extend beyond their original margins, whereas the allografts would lose their pink color and start to melt away. I wondered how the body could distinguish between these cells? What was the process of rejection? No one seemed to know. This stimulated my introduction to transplantation biology.

After my army discharge and completion of surgical and plastic surgical residencies, I joined the renal transplant team at the Brigham Hospital. Although they were studying end-stage renal disease and I was more interested in the skin, I reasoned that the transplantation biology of a kidney would apply to skin as well. Whether my decision was serendipitous or "chance favoring a prepared mind," I don't know, but it led to a lifetime of clinical research.

My first collaborative work was with the medical and pathology services—a study of serum complement levels in the rejecting dog kidney. My first individual surgical project was the development of an operation for the permanent survival of dog kidney transplants.

After extensive collaborative studies by all services, we reached the stage when we were ready to transplant a human kidney from a living donor. Further details are given in my Nobel lecture; for this occasion it is sufficient to state that in December 1954, at the old Peter Bent Brigham Hospital, I transplanted a kidney from a healthy identical twin to his terminally ill brother, using the exact surgical technique developed in the dog lab. This was the world's first successful solid organ graft, and it had a worldwide influence. In January 1959 I performed the world's first successful kidney allograft from a nonidentical twin brother.

During the '50s in the Surgical Research Laboratory—then in Building C, now in Building E—we performed a variety of skin and kidney grafting experiments on mice, dogs, sheep and rabbits using total body x-ray and bone marrow infusions for immunosuppression. In 1960 we investigated the use of immunosuppressive drugs in canine renal transplants. This led to the first successful allograft of a human kidney from a cadaver in April 1962. After it was reported in the *New England Journal of Medicine* a year later, other clinical transplant units were started all over the world.

The drugs azathioprine and 6-Mercaptopurine were synthesized by

our collaborators George Hitchings and Trudy Elion of the Burroughs-Wellcome Company. Both were awarded the Nobel Prize in Medicine in 1988 "for their discoveries of important principles of drug treatment." There is a picture of them taken in 1961 with our group in the corridor of Building E.

We lived in a marvelous setting: hospital and laboratories side by side, all departments cooperating. We all felt totally at home in each other's labs. We also worked with other Quadrangle groups when indicated, i.e., Cliff Barger '43A in physiology, Guido Majno in pathology, Bernie Davis '40 and Albert Coons in microbiology. This was the ambience, the substructure that was the foundation for the first successful human organ transplants.

Throughout these years of involvement with experimental and clinical transplantation, I have continued to do reconstructive surgery, especially for facial deformities of congenital, traumatic or neoplastic origin. In the mid-60s I formed the first plastic surgical residency program in Boston, a combined program at the Children's and Brigham hospitals. The craniofacial program, like our transplant one, is multidisciplinary and includes orthodonture, oral surgery, neurosurgery, ophthalmology, nursing, social services, speech and hearing, psychiatry and administration.

Correction of facial deformities not only can restore function, but also can have an enormous effect on the quality of life and self-esteem of the individual. Many patients have changed from recluse to normal living. Understanding congenital deformities involves a study of many disciplines here in the Quadrangle, such as genetics and embryology.

From these remarks, it is obvious that no one person is responsible for medical progress. We all are part of a team and depend on institutions, granting agencies, understanding administrations, dedicated dependable nurses, social workers, technicians and research fellows.

When I received the Nobel Prize last December from the hands of the King of Sweden, I was thoroughly aware of the many who have contributed to making organ transplantation a clinical reality. I thought of HMS and the hospitals that nurtured me, of the wonderful persons involved: George Thorn, Francis Moore, John Merrill, Hartwell Harrison, Gus Dammin, Jim Dealy, Dave Hume, and the hundreds of residents and fellows. But most of all I thought about the thousands of patients now living all over the world with transplants not only of kidneys, but also of livers, hearts, lungs, combined heart-lungs, pancreases and intestines.

E. Donnall Thomas '46, my co-recipient of the Nobel Prize, and I both are pleased that the Nobel Foundation has recognized that clinical research is as important as basic research. We must shorten the distance from bench to bedside. We clinical scientists have the opportunity to witness all sorts of biological problems screaming for solutions. Clinical research can be a spirited study involving innovative collaborations and new perspectives.

There is no magic formula to achieve the proper balance between clinical care and research. Follow your dream, work hard, it can be done. I assure you it is worth the struggle.

In spite of current laments about medicine as a profession, malpractice, excessive paper work and third-party interference, the future for medicine is brilliant. Now is the best time in all of history to be a physician. We can diagnose and treat conditions in ways unimagined just five or ten years ago.

Our school is preparing for its third century. It is a fortunate privilege and heritage for you to maintain and enhance. I have no envy of your future opportunities; my life has been blessed beyond my wildest dreams.

Dean Berry, dean after World War II, quoted Thoreau at his last HMS faculty meeting: "If one advances confidently in the direction of his dreams and endeavors to live the life which he (or she) has imagined, he (or she) will meet with a success unimagined in common hours."

Each of you is struggling to decide your own niche in the medical world. To you I can only offer my own prescription for establishing priorities. The choice is not between "good and bad." All your priorities are good, and you must choose between "good and good." We are among the most fortunate on earth; we have all had good educations and have a choice of ways to improve the health of society. Most

of you probably will provide direct patient care, others will opt for public health or government service, or some may seek additional education in business or law.

Keep an open mind about the vagaries of life. Some of my most unwanted assignments turned out to be my most rewarding ones. Regardless of your choice, success and happiness will be determined by your enthusiasm, stamina, dependability and hard labor. To quote a former chief of surgery of mine, "Nothing worthwhile in this world is accomplished without *labor.*"

The title of my talk today, "The Best Is Yet To Be," is a line from one of my favorite Browning poems: "Grow old along with me/ The best is yet to be/ The last of life for which the first was made."

I realize that you cannot grow old along with me, but I hope I can perhaps stay young in spirit with you. Ponce de Leon searched in vain for the fountain of youth. But I know of no place better to be eternally youthful and optimistic than here at HMS. I can never repay our school for widening my horizons, supporting my hopes, fulfilling my professional needs and keeping my eye firmly on the future.

In addition, I must tell of HMS's greatest gift to me. I met my wife at a Vanderbilt Hall party during my last year of medical school. For the past 47 years we have shared our lives with splendid colleagues, faculty and students.

Many associates of my vintage complain about today's students. "The students today aren't like they used to be" is a common litany. When I hear this I immediately respond, "You are absolutely right. They are a helluva lot better!"

We all have much to be thankful for. We have "been warmed by fires we did not build and have drunk from wells we did not dig." Last week at a medical meeting I heard a remark that is a fitting final statement for this talk: "Service to society is the rent we pay for living on this planet." □

Joseph E. Murray '43B is professor of surgery, emeritus *at Harvard Medical School, and for 34 years was chief of the division of plastic and reconstuctive surgery at both the Brigham and Women's and Children's hospitals. He is also chairman of the Harvard Medical Alumni Fund.*

A Sense of Responsibility

by Jonas Salk

Participating in this commencement has been one of the most inspiring and moving experiences that I've had. I truly feel as if we are observing the flowering of humanity.

As I reflect upon the state of the art and science of medicine on the occasion of the commencement of your careers, as compared to the beginning of my life's work 52 years ago, I am in awe as I cast a glance into *your* next half century. I say your next half century because, when all is said and done, it becomes self-evident that our past, as will be true of the future, has been shaped by the expanding dimensions of the human mind.

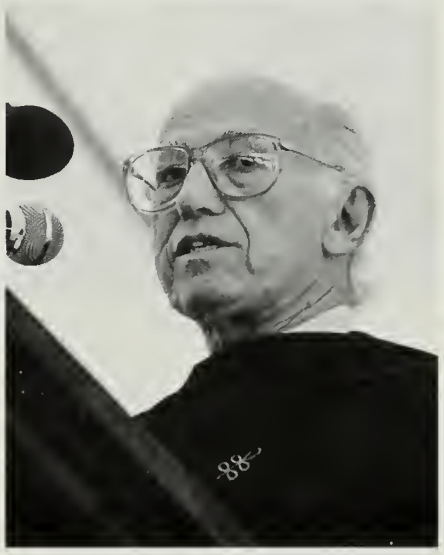
One might well ask, what were the challenges of my generation, and what will be the challenges of yours? What will be different and what will be the same? Just as each age is golden in a different way, each generation has the opportunity to make of it what it will.

It would hardly be fitting at this moment to do more than suggest an attitude, a way to approach your future as physicians and scientists who will deal with human health and well-being. As I have observed what has been happening over time, it is evident that we have come a long way in controlling disease through our understanding of the biological dimensions. We are now in need of understanding the human dimensions as well.

When I speak of the human dimensions, I am thinking of the self that lies within the nucleus of the human atom, with its quantum of desire and its telos or purpose, which is expressed in the ability to choose and assume responsibility, and in so doing, to survive and evolve as individuals and as a species.

It is clear that each of us has particular affinities, sensed intuitively through our feelings of satisfaction as well as through the effects produced by our actions and the successes achieved. We need to follow our inclinations in this regard.

Over the course of a lifetime, it is the role played by our individual purpose and sense of responsibility, as displayed by the choices we make, that evokes the potential that we possess. In making these choices we will, hopefully, each in our own way, become examples that others may follow. In this regard, each of us is born to contribute in a different way.



Looking at my own life, I can now see how desire and a sense of responsibility have allowed me to channel my own career. When my responsibilities for the initial work on vaccination against polio were completed, I was asked by Alan Gregg of the Rockefeller Foundation what I would do next. Before I could reply, he interjected, "Whatever you choose, do that which makes your heart leap." This comes to mind as I contemplate the transitions that you now face and will continue to face as you progress through the stages of your lives.

While I would give you the same advice today, I have also learned that there are two great tragedies in life: to not get what you want and to get what you want. It was because I was denied my desire to pursue studies on rheumatic diseases during an elective period in medical school that I found myself in a laboratory concerned with studies on influenza. Ultimately this

Bonnie Ross snaps some pictures of her own.

opportunity, which was not my preferred choice, proved to be of even greater good fortune, because it broadened my experiences so that I would be able to direct my career and assume the responsibility to meet the needs of my time.

I had always intended to engage in research, and I accepted an opportunity to leave my class at the end of the first year to become a research fellow in biochemistry. At the end of that year I had an opportunity to continue in the field of biochemistry. However, I chose to remain in medicine rather than be limited to a field of science only remotely related to matters of medical and human interest. Later, after my internship, I had an opportunity to become a surgeon. But, I declined, preferring a career in laboratory and clinical research to continue my interest in what was later to be called vaccinology, a science that I sought to develop from the art that it had been at that time.

The challenges I chose were also defined by the needs of the time. As a child I had observed the tragic consequences of the 1916 epidemic of poliomyelitis in New York City, and of the 1918 pandemic of influenza. While I do not recall being influenced by these experiences in a conscious way, the need to control these infectious diseases was apparent. It seemed natural, therefore, for me to choose this ripe and fruitful field in which to work.

After the work on influenza and polio, and in the course of exploratory studies on immunotherapy of cancer and of autoimmune disease, I saw the need for fundamental studies required to address clinically applicable ways to control such diseases. The value of combining the fundamental and clinical approaches is evident in my current interest in the prospects for immunotherapy and immunoprophylaxis of HIV infection.

I also began to appreciate the human side of nature and of science. It was with this in mind that the Institute for Biological Studies was created to deal with the human as well as the biological dimensions in health and disease.

My continuing interest in the human side of nature is why I chose to address some of the broader questions concerning the evolution of human health and disease in our time, rather than to practice clinical medicine, involving individual patients. I had a desire to serve as a physician to humankind, in whatever way this might be done. Drawn to certain questions I chose to ask, I found that I too was chosen by the opportunities afforded by having been in the right place at the right time. Whatever the dynamics, they depended upon human qualities, one of which is a sense of responsibility.

Fifty-two years later, as I pursue my interest in the prospects for immunotherapy and immunoprophylaxis of HIV infection, it continues to be evident to me that the choices I have made have been out of this sense of responsibility.

And so it would seem that each of us has an opportunity to play a far more important role than may be apparent at first glance, and to do so individually as well as collectively, and not to leave such matters to others or to chance alone.

It may be up to the professions—perhaps influenced by the most interested physicians and scientists, given our instinct for healing—to begin to address the needs of the person, of the relationship of person to person, and of the person to and within society.

Who else, by profession and commitment, are better prepared to assume their share of responsibility for the future of the current generation and the generations that are to follow? We are speaking about our children, and our children's children, and all of the future generations for whom they too will be responsible. Not only will we have to care for many more individuals, with all the diversity that this implies, but also we will have to care for and maintain the health of more human gray matter than ever before.

In this regard, I have the sense that our humanity is being tested for our ability to deal with the morbidity and mortality for which we are the pathogens, acting both upon ourselves and others. In what way is this attributable to nature and in what way to nurture? How can such a question be addressed?

What we *can* say is that such behavior is, in effect, a product of evolution, with diversity seen not only in the different cultures and societies in the world but in our own culture and society as well. Rather than despair about what this implies and about all that

Charles Moore (left) and Selwyn Rogers

remains to be achieved in this realm, I see hope. I sense in many whose careers have commenced in recent years, a continuing interest and zeal to improve the quality of human life in all of its many dimensions. And I hear it reiterated here by you.

Hopefully the instinct for improving the human condition will prevail, and the wisdom needed to put to use the knowledge that we already possess will be brought to bear. It should be evident, from this perspective, that the challenges of the past were simple as compared to those with which we are now confronted.

It will be through our sense of responsibility, not only for the needs of our patients, but in a larger sense, for the health and well-being of humankind, that these challenges can be met. There is a need for physicians, scientists and others who have concern for human life to work together toward improving health and well-being in all of its dimensions. If we do not, who will be to blame for the future, to which we and our ancestors will have contributed? How will we be looked back upon by those who follow.

There is a need for each generation to set its own goals, its own hopes and purposes. Through the acceptance of responsibility to take the initiative, each generation creates the possibility for a better today and an even better tomorrow. Through the strength and power of hope, a sense of responsibility can be made operative.

Therefore, there is a need to expand the number of those with these concerns from the few to the many, and to do so by example. It will be through the process of self-selection that the like-minded will come together to form natural relationships to change the quality of life, their own and the lives of those with whom they come into contact. There can be a more positive vision, a more hopeful vision, through assumption of this responsibility.

You come upon the scene at an important and meaningful moment in human history—I might even say, human evolution. You and those who follow will carry a greater burden, not only in the practice of your profession, but to help others see what you see, to know what you know, and to do what wisdom dictates for the maintenance and enhancement of human health and well-being.

This will require those with courage to take responsibility for the initiative needed to implement the realization of the visions you have. In this way, you will go far toward the ultimate that can be reasonably achieved, and in the process you will be amply rewarded for a job well done by the opportunity to do more. □

Jonas Salk, MD is distinguished professor in international health sciences and founding director of the Salk Institute for Biological Studies, La Jolla, California. He received his MD from NYU College of Medicine in 1939. He developed the first polio vaccine at the University of Pittsburgh in 1953. At the Salk Institute he is engaged in studies in the immunotherapies of immune disease and cancer, and he is currently engaged in studies in the immunotherapy and immunoprophylaxis of HIV infection.

Lessons from Doogie and Henry

by David S. Greenes

I've been watching a lot of "Doogie Howser" lately. I don't know if you all are Doogie fans too—if you're not fourth-year medical students, you may not have as much time as I do to watch Doogie—so I'll tell you a little bit about the program. The protagonist, Douglas Howser—who goes by the nickname Doogie—is a 16-year-old medical resident. You see, Doogie is a genius. He got a perfect score on the SATs at age 11, finished college and medical school in five years, and now is beginning his residency.

Doogie seems to be a resident in internal medicine. But that isn't completely clear, because he does work that you might expect would be done by other specialists. This season alone Doogie has performed an emergent appendectomy, delivered a couple of babies, counseled an alcoholic, and completed a corneal transplant. I just don't know how he does it.

I guess it's obvious that I'm a real Doogie Howser fan. But you know, lately I've become a little disillusioned. It's just that, well, I'm beginning to think that maybe the program isn't all that realistic.

I mean, here I am, just having completed four years of Harvard Medical School, and about to begin my residency. I'm at about the same stage of my training that Doogie is in his, so how does Doogie's fictional life compare to my real life situation? That's what's made me wonder about the show's realism.

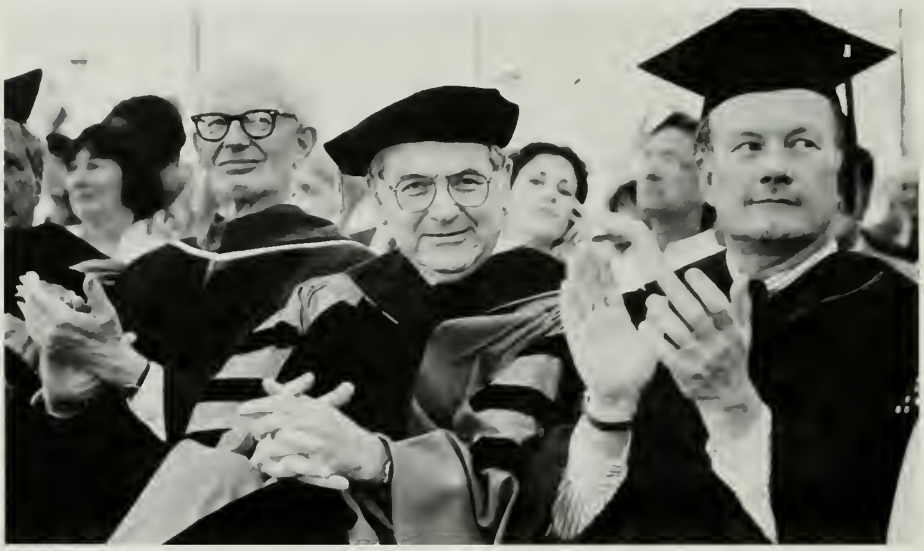
I mean, here's a guy who as a medical intern is still psychosocially an adolescent. In one of the first episodes, for instance, Doogie had his first kiss. . . . All right, so maybe that part is realistic enough. But this guy, this adolescent, so young and naive, still fresh out of medical school, can do everything. I can barely put in an IV, never mind transplant a cornea.

What's worse, Doogie *knows so much*. He never hems and haws. He never calls a consult. Doogie never says, "I don't know." And that's why I

think he couldn't really be a doctor.

A lot of Americans probably believe in Doogie. After all, he is really just an exaggerated version of the all-knowing doctors we've seen for years on stage and screen. Names like Kildare, Casey, Welby, Huxtable and Doolittle conjure up images of well-rested, white-coated, competent doctors who always know the answers. This is what America thinks doctors are.

At times I get scared when I think about that. Maybe America is right. Maybe all doctors do know everything, and I'm the only one who doesn't relate to Doogie. Maybe I should have been studying the kidney way back when, instead of doing the hula in the second-year show. But I know I'm not the only one who worries this way.



Masters of the academic societies did the "hooding" this year. Walter Abelmann (co-director of the HST division), Ronald Arky (Francis Weld Peabody Society) and Roger Mark (HST).

Throughout my four years my teachers have been reassuring me that feeling like you don't know enough is universal in medicine.

I remember the orientation meeting for my first clinical clerkship, internal medicine at Massachusetts General Hospital. The tension in the room was palpable as we third-year students huddled in terror before the imposing figure of Dr. Leslie Fang, our course director. To our pleasant surprise, Dr. Fang was remarkably understanding. "I bet you're all terrified," he said. We nodded. "You probably feel that you know nothing, and you can't believe we're letting you onto the wards. Why, I bet you think that even the housekeeping staff knows more medicine that you do." Sheepishly, we nodded again.

"Well, you're right," he said, smiling warmly. "The people from housekeeping do know more medicine than you."

Feeling like you don't know enough isn't easy. One response to this feeling is to try to become that rare doctor who, like Doogie Howser, actually does know enough. Maybe if I just study a little harder, the reasoning goes, I won't have to worry about my competence. I think we all tried that during one part of medical school or another. For me it was Anatomy, our first course. I counted the number of pages in our textbook—Snell's *Clinical Anatomy for Medical Students*—and divided that number, 1,026, by eight weeks. That was 128 pages a week, or just 18 pages a night. The first night I read two pages. I woke the next morning with a diagram of the spleen imprinted on my cheek. That night I read three pages more.

Clearly I wasn't going to finish all 1,026 pages. Okay, I realized, maybe I was being a little over-ambitious, a little compulsive. All right, so I won't read the index. That leaves 984 pages. Okay, that's still too much. Maybe I'll just skip the head. If I know everything but the head, I'll still be in good shape.

Sooner or later (and for me, it was sooner), every medical student comes to learn that he's not going to make it through all the books. Or maybe even all the major organs.

Huge unread textbooks are enough to make any aspiring doctor feel insecure. But what makes matters worse is that doctors, at every stage of their training from third year of medical school on, are continually thrust into situations they don't feel quite prepared for. Even though your competence grows gradually, incrementally from one day to the next, your level of responsibility increases in sudden, terrifying bursts. Just as you're getting the hang of being a fourth-year medical student, you're ripped from the womb and given a beeper that actually goes off. It can make you feel like an impostor. I may be a doctor today, but I don't know any more than I did yesterday, when I was just a medical student.

I will learn, of course, but I'll learn by doing. When I was a young boy, I was always confused by the phrase "to practice medicine." To me, the word "practice" conjured up images of long painful afternoons at the piano, fumbling through "The Spinning Song" or the "Baby Elephant Walk." "To practice" meant to rehearse something you didn't really know how to do. When I heard of doctors practicing medicine, I imagined myself saying, "No offense, doc, but if you're still practicing, I think I'd prefer someone else who's already got it down."

This might seem like just a child's misunderstanding of subtle connotations of language. After four years of medical school, though, I realize that my childhood intuition really wasn't far off.

And that would be fine, if my job weren't such a serious one. The thing is, while I'm learning my craft—while I'm practicing—I'll also be responsible for my patients, in some cases having a direct effect on whether or not they live through the night. When internship scares me, it's not so much because of the tremendous workload or because of the sacrifices I'll have to make outside the hospital. What scares me is thinking that my not knowing something might really hurt someone.

This isn't the first time I've had this fear. And I know I'll continue to feel it throughout my training. In fact, perhaps I'll never stop feeling it. Over four years I've come to learn that not knowing is really central to the task of being a doctor. You never have as many facts as you would like. Patients often cannot remember important details about their history. Lab tests always have some degree of error. And sometimes even the best imaging techniques can't show you what's going on inside a patient's body.

Furthermore, many things we deal

Emily Ceisler and Mark Blitzer compounded their graduation celebration with their wedding in May.

with in medicine aren't known by anyone; even the mechanisms of the treatments we offer are sometimes a black box. With every patient encounter, there is some degree of uncertainty. Rather than aspiring to know it all, therefore, a doctor needs to become comfortable with the limits of his/her knowledge.

Perhaps a better hero than Doogie Howser for young doctors like us is Henry Adams, the grandson of John Quincy Adams. Adams attended Harvard between 1854 and 1858, and he wrote about his experiences in his autobiography, *The Education of Henry Adams*. (I can see my parents beaming with pride now, relieved to see that after four years at Harvard, I can quote from something other than bad TV shows.) Upon concluding his Harvard education, Henry Adams wrote, "As of yet I knew nothing. Education had not begun. . . . [Harvard] taught little . . . but it left the mind open, free from bias, ignorant of facts, but docile."

I don't agree with Adams that I've learned little at Harvard. But I do admire him for facing the limits of his knowledge so frankly. I think he realizes, as all doctors should, that you cannot punish yourself for what you don't know. It's only natural not to know. Learning in medicine is a lifelong process, and it's only beginning now. As Adams says, "[The graduate] knows little, but his mind remains supple, ready to receive knowledge."

This idea may be humbling, but it's also liberating. It frees you from the paralyzing belief that you must know it all to be a good doctor. And it teaches you that a good doctor doesn't go through medicine alone.

This may seem obvious, but it's easy to forget. It's tempting in medicine to confuse competence with self-sufficiency. In the hospital to need help is often made to seem weak. I remember the first time I drew an arterial blood sample by myself. I had watched residents do the procedure, and I had done it with their help a couple of times. Now another patient of mine needed a blood gas done.

"Do you want me to come help?" my intern offered. "No," I answered, bristling with pride. "I think I can do it myself."

I was nervous, but I tried hard not to show it. Quickly, I gathered my equipment, straightened my tie, and buttoned my white coat. I walked boldly into my patient's room.

"Hello, Mrs. Jones," I said. "Just need to draw some blood." Very business-like.

I felt carefully for Mrs. Jones's radial pulse. I marked the spot mentally, cleaned it thoroughly, gloved, positioned my needle, held my breath, swallowed hard and stuck. I watched the needle hub expectantly. Nothing. I moved the needle forward slowly. Still no flash of blood. Then I got more aggressive, pushing the needle forward and back in different directions. Mrs. Jones squirmed with discomfort, but politely and stoically said nothing.

"Hmmmm," I said with a knowing air. "The artery must be in spasm. I'll have to try again."

I pulled the needle out, and Mrs. Jones shook her head, but still said nothing. Now I tried the other arm. Again, I palpated, marked, prepped, positioned, swallowed and stuck. And again, nothing. I fished for a few minutes, but still no blood.

I started to get nervous. I really didn't want to call my resident after having been so cocky before, but I didn't want to cause Mrs. Jones any more pain. "I don't know what's wrong, Mrs. Jones," I bluffed. "I never had had this much trouble." That was true, I never had had this much trouble. But I had only done this procedure twice before. I started to gather my stuff; I was going to have to call the resident.

Mrs. Jones was still holding her breath and grimacing, but finally she spoke. "You're not holding the needle right."

"What's that?" I asked.

"Listen, doc," she said. "I've had this done a bunch of times. I think you have to go in more horizontally. You were doing it at too much of an angle."

For a second I flushed. My cover was blown. Even my patient knew how to draw blood better than I did. But then I thought about it. I'd only been doing this for three weeks; why should I expect so much of myself? I realized that if I feign competence now, I'll be feigning it for life. You can only learn if you can admit that you need to learn.

So I set up for a third needle stick, this time with Mrs. Jones courageously guiding me through the procedure. And I've been much better at blood gases ever since.

I've also been better at asking for

Tia Horner (left) and Lisa Leffert

help. I've come to see that it is a sign of strength, not weakness, to be able to learn from others. Not knowing something won't get me into trouble next year. Not admitting what I don't know, though, might.

Taking the words of Henry Adams to heart, I've come to accept limited knowledge as a given. At the same time, I've become more comfortable with the responsibility I'll have, because I trust that I'll be able to ask for help when I need it. I realize I'm no Doogie Howser. But like Henry Adams, I find strength in that realization.

David S. Greenes '91 is now a resident in pediatrics at Children's Hospital in Boston.

Susan Abookire

The Learning Curve: Slippery When Wet

by Elizabeth S. Biegelsen

Yesterday we were poor, miserable students, never having ventured beyond the MEC atrium (except to Sami's). But today, we graduate! Tomorrow we will be poor, miserable interns.

We have earned the right to sleep several hours a week whether we need it or not, to write medication orders without having them co-signed, and to stop paying the medical school and start paying the bank. Tomorrow we will be doctors. I have a sudden, uncontrollable urge to throw up.

Just kidding. Of course, I'm very excited about becoming a physician. Sure, it'll be great. Think about it. Your relatives will be much more impressed with you now that you're a *real* doctor. Patients will expect you to know something relevant about medicine. And when someone in the hospital hallways calls you "honey," you can whirl and say, "That's *Doctor* Honey to you!"

There really is only one thing to do in the face of such great honor and responsibility—RUN AWAAAAY!!! When Dean Tosteson approaches you with his most congratulatory smile, ready to hand you that diploma, JUST SAY NO! Resist the peer pressure. Sure, all your friends are doing it. Everyone else is doing it. But as your parents always told you, you're not everyone else.

Let's assume that most of us aren't quite strong enough to turn back now. And in reality, the degree was so darned expensive and there are all these people here, so it would be really embarrassing to make a scene. That means that we will have to be doctors. Soon. Along with our feelings of gratitude for the support of family and friends, and palpable relief that medical school is finally over, on this momentous occasion, I for one am experiencing sheer terror.

Since beta-blockers can only do so much, some of my future psychiatrist friends have suggested that I try to discover the source of my fear. It's not patient care that scares me. After all, most people will have diseases like leischmaniasis or neurocysticercosis, and we've seen plenty of those. Besides, the resident will always be there to help us, right? Right?

It's not because of the incredible time commitment and sleep deprivation. We did that with the second-year show. My fear centers on something we never learned to do: how to teach medical students.

I realized this partway through my third year, so I began to jot down examples of how to interact with students and other such clinical pearls, in this little notebook. For those of you unfamiliar with the little black book, every medical student seems to have one. I assumed everyone else's book was just like mine, until I saw Nora Jaskowiak's book. *Hers* was chock-full of vital information: notes on eponymous syndromes, experimental treatment protocols, the formula for the fractional excretion of sodium and other useful minutiae. I had some serious catching up to do.

Nethertheless, I would like to share with you a few pages from my little black book on the subject of teaching medical students, as taught to me and my colleagues by our residents and attending physicians.

Page one. First, while time is of the utmost importance to you as a house officer, medical students' time is not important. They have lots of time. Therefore, you should be sure the student is the last person to see the patient. If possible, arrange to have patients sent up to the floor before your

student gets to examine them. (Even better if the patient is asleep before the student is called.)

Students do, however, like to feel needed, so assign them jobs such as photocopying articles, buying you coffee, and picking up your dry-cleaning. Occasionally, on a beautiful spring day when you would much rather be outside, and your student is finished with all of her work and there is absolutely nothing educationally relevant for her to do, send her home. But make her feel really guilty.

Next page. Learn to "pimp." (Pimping is defined as the relentless questioning of medical students by interns, residents, attending physicians, nurses, patients, candy stripers . . . Equal time is given to matters both important and unimportant.) This skill is especially vital if you expect to have an academic career.

Start practicing now. Pimp your friends, be they medical students or not. Pimp your patients. For example, "Mr. Jones, do you have that recent review article on diabetes insipidus for me, and a bullet summary of your relevant clinical findings?" Pimp the first-, second- and third-year students. (But be careful. They still remember stuff. Make them play "guess what I'm thinking" instead.)

Page three. House officers have no time for chitchat. Let your medical student provide the empathy for the patients. They've been trained—they've taken Introduction to Clinical Medicine (or some reasonable facsimile)—and what's more, they liked it. They'll provide all the caring that's needed.

Page four. Remember, medical students are not real people. So you should never introduce your medical student to your friends. This is especially true when meeting fellow house officers at mealtime. If you must refer to your medical student directly in the presence of others, be sure to call her "the medical student." There's no need to invite your student to go to dinner with you, unless she has extra meal tickets. Feel free, however, to mention the availability of free food *after* the fact: "Oh, you missed the drug lunch catered by Maison Robert? It was great."

Page five. Since they are not real people, medical students have no feelings. This allows you to make statements that would ordinarily be considered hurtful and rude, such as racist, sexist or homophobic comments. It also gives you the opportunity to confide the most intimate details of your personal life to your medical student, without ever asking about her life.

Page six. Every few days, buy your student a cup of coffee. Spend a couple of hours with her going over the basics of her case, ask her what she thinks and how she would like to manage the patient, help her with her presentation, teach her what you know. . . Hey, how did that get in here?!

Page seven. Finally, be sure to constantly refer to how difficult things were for you when you were a medical student. (If you are an attending, this works equally well on residents.)

I've been thinking about why people do this—why, in fact, I'm doing it now. It seems the bad things that happen to us stick in our minds. Being a medical student hasn't been easy, sometimes in ways that we didn't expect. I imagine that being a physician will likewise bring unexpected challenges and hardships, especially as the responsibility gets bigger and our time gets shorter.

We may feel that we have grown a bit cynical in our years at HMS, but a day like today reminds us of the good things that have happened here. There were kind and caring physicians among the house staff and faculty who made us want to be like them. There were patients who let us draw their blood one last time, who didn't complain when we listened for their heart murmurs over and over again, and who occasionally made our day by calling us "doctor."

And there are our families, friends and significant others, whom we have bored to tears with our case presentations, and who are so very proud of us. We wish we could thank you enough for all you've done. We can try to keep our ideals untarnished and work to achieve them. And we can strive to remember the love and support we have received from our families—and also from each other.

I'm sure everyone thinks her own class is particularly special, but this is my class, and I do think we're special. We have met people here who not only studied with us, but also partied with us at the end of a clerkship. People with whom we sang and danced in the second-year show were also there for us when we were on the verge of a nervous breakdown.

We're graduating now, and some of us are moving away. But these friendships won't be quick to fade. Because friends who could stand you for these four (or more) years can certainly stand you for a few more. By caring about each other, we've learned a lot about how to be caring. We won't forget that.

And so, if we do decide to succumb to peer pressure and accept our diplomas today, we know that we'll take with us more than our degrees. We'll also take the friendships that we have found here. And maybe *our* students will learn different lessons. If we can teach them some of what we've taught each other, I know they will.

Elizabeth S. Biegelsen '91 is now a resident in medicine at Boston City Hospital.

Graduate Stephen Gund's family help celebrate.

William Potter '41 (left) and Edward Ahrens '41 attend the scientific symposium.

Alumni Day

Celebrations of the old are often good times to introduce something new, and the 100th anniversary of the Alumni Association was no exception. First off, Alumni Day was true to its moniker this year as a full day was given to the proceedings—a change from the half-days of past years. This format gave ample room to discuss the results from the alumni survey on physician satisfaction in the morning, and other issues in the afternoon.

Secondly, the Alumni Day format brought the exchange of ideas that usually occurs in small groups over lunch into the open. Microphones were planted in the aisles to encourage attendants to come forward and respond to or ask questions of the panelists. Resembling an HMS town meeting, alumni queued up to the microphones to offer their thoughts.

Another change from past years: the 25th-year reunion class held its symposium on Thursday, alongside the scientific symposium called "Science, Ethics and the Future of Practice" sponsored by the school. (A student's reflection on the symposium and its impact on his future medical career is included in this issue.)

The Class of 1966's talks were scientific and artful. Among the many presenters were Michael Marmor, who debated the optical conditions in artists, such as how Monet's cataracts may have affected the paintings of his later years. David Dale talked about his involvement in a promising new therapy for neutropenia. Eugene J. Mark divulged the secrets of deciding which MGH CPCs go into the *NEJM*.

Ned Cassem thoughtfully discussed physician-assisted suicide. He expressed his fear that the psychic and spiritual pain of a patient are commonly neglected in this debate, and suggested that "rather than cause a patient's death we should first do more to relieve suffering."

Richard Hannah considered his career as an internist and asked: what is the role of a general practitioner? "To be a kind of second string utility infielder? A referral service? A physician finder who gets the patient to the cardiologist, the surgeon, or some other *action* doctor, who can take charge? Is an internist a Jack of all trades, master of none?"

James S. Gordon told a story of how a personal illness led him to reflect on his role as a physician, and to contemplate both his life in medical school and in returning. Joan Lamb Ullyot reflected on her transformation from having never heard of the Boston Marathon to holding the record for women marathon runners in her age group.

Others, who discussed a variety of topics from life inside HCHP to medical editing in the 1990s, were John M. Ludden, Barbara J. McNeil, Robert H. Fletcher and Theodore P. Pincus. On a final although fitting note, David Scharff (whose talk is reprinted here) reflected on reunions and reunioning.

Friday morning began with the annual business meeting. William McDermott '42, director of alumni relations, provided the opening remarks on the anniversary of the 100th year of the Alumni Association. "Few of us are left who remember the founding of this," he quipped. "It's a little

PHOTOS BY JERRY BERNDT

shady, but I think I can remember."

McDermott, President Robert Goldwyn '56 and Samuel Katz '52, secretary, all made special note of the efforts and "imaginative leadership" of Nora N. Nercessian, PhD, executive director of the Alumni Association.

Goldwyn, before beginning the meeting, looked out over the gathering of reunioning and nonreunioning alumni and said, "Considering that we are 100 years old, we look in pretty good condition. Of course, as a plastic surgeon, I'm well aware that appearances can deceive."

In his report of the alumni fund, Chairman Joe Murray '43B commended the alumni for their high participation rate. Alumni, he said, have contributed over $6 million to the Campaign for the Third Century of Harvard Medicine.

Among the fund-raising tactics, said Murray, were the phonathons with student callers. To speak for the success of this effort he read a letter from an alumnus who had never contributed until a female student called him. The writer, who said he had graduated 20-plus years ago, said he didn't often get the opportunity to talk to such intelligent women. He enjoyed the call so much he contributed $500.

Al Pope '41 presented the class with a 50th reunion gift of $129,000 from 76 of 94 surviving classmates—an 81 percent participation rate.

Goldwyn's final act as president was to pass the gavel to his successor, George Bernier '60. With Goldwynian wit, the outgoing chief executive remarked about Bernier, who is dean of University of Pittsburgh School of Medicine, "George has agreed that he will accept my position, but I won't accept his."

COMMENT

I've been a cardiac surgeon for 25 years. I'm a test pilot. I push the envelope every day, Monday through Friday—take my machine right to the limit. The difference between me and the other kind of test pilot is my machine is a human being. The other big difference, real difference, is when I crash and burn, I'm not the one who dies.

—QUENTIN STILES '51

After business closed, the symposium began with a discussion of the results of the alumni survey of professional satisfaction. Floyd J. Fowler Jr., PhD from the Center for Survey Research at the University of Massachusetts/Boston reported that, for the most part, HMS alumni were satisfied with their careers (see the *Bulletin*, Spring 1991).

He acknowledged, however, that some things were hard to measure. Movable standards, he said, include such problems as the impossibility of answering how good is good enough, and he suggested that there are great differences between people's general attitudes and their own personal feelings about the same issue. For example, physicians might think that the medical profession in general is in bad shape, but feel that their own experiences are positive.

E. Langdon Burwell '44, chairman of the Survey Committee and Marilyn Karmason Spritz '53, a member of the committee, provided commentary. Burwell pondered how to correlate the survey results, which show that about 80 percent of those surveyed are satisfied with their careers, with the often heard expressions of dissatisfaction.

He questioned results that show that HMS graduates are a "band of we happy few." His experience says no, he said. He encouraged all to maintain hope on these problems and suggested working through medical organizations and the political system to bring about change.

Spritz concurred somewhat with Burwell and focused on three large areas where physicians have problems: money, space and time. Money problems include those related to high malpractice fees and lowered income due to policies of third-party payers. It is a rare practitioner, she said, who has not had the problem of finding a hospital bed in an emergency. And time, or lack of time, to spend with patients, doing research and with family is a constant problem. She felt encouraged, however, that by working together, HMS graduates could alleviate the problems facing their profession.

"A Nobel Moment" closed the morning session. Dean Daniel Tosteson '48 applauded the accomplishments of two HMS "sons," Joseph Murray '43B and E. Donnall Thomas '46, co-recipients of the 1991 Nobel Prize in Physiology or Medicine. A heart-felt standing ovation was a fitting show of appreciation, pride and commendation.

The afternoon session began with a panel entitled "Issues in Providing 'Health Care for All'." Moderator Barbara J. McNeil '66 contemplated the "bad news" of the current health care system and presented some worrisome issues, the most disconcerting being that 33 million individuals in the United States are uninsured. James

E. Langdon Burwell '44

Marilyn Karmason Spritz '53

Out-going president Robert Goldwyn '56 passes the gavel to his successor, George Bernier '60.

Todd '57 and James O'Connell '82 addressed two perspectives on quality and access for the less financially fortunate segments of our population.

Todd unveiled the AMA's new plan, called Health Access America, designed to "broaden access to care by standardizing Medicaid throughout the country." O'Connell spoke of how providing medical care to a homeless population is a daunting but rewarding task, and he urged that this type of work "not become the domain of zealots and saints."

Paul Davis '63 moderated a panel on "Redressing the Wounds: Professional Liability and Intrusion of the Third Parties into Practice." He addressed what he termed an emerging "literature of physician discontent" and discussed both the old refrains and the new problems. Barry Manuel, MD and Harvey Klein '63 discussed the problems of, and possible solutions to, the issues of physician liability.

Manuel, after deciding that Shakespeare's recommendation to "Kill all the lawyers" was not the most feasible, proposed a patient compensation (no-fault) plan as a means of handling patients' undesirable outcomes. Klein discussed the effects of the Libby Zion case in New York. He focused on the anguish the case caused Zion's physician, and called for a psychologically more sane approach to legal/medical conflicts.

And so concluded the 100th gathering of the Harvard Medical School Alumni Association. Alumni went away with a feast of issues and ideas to ponder, discuss, and hopefully solve in the next 100 years of association.

Issues in Providing 'Health Care for All'

Earlier today, we had the "good news." This afternoon, we must consider "bad news," and review a medical system that gives us so much satisfaction as individual providers, that improves the quality and quantity of life of many sick individuals, but that simultaneously has limitations.

The United States today is facing a major crisis in its health care system. In the past, concerns about the system involved erudite discussions among health care economists and policy makers. Today, the discussion has escalated to a level involving the lay press as well. The *New York Times* and the *Boston Globe* have had thoughtful pieces on Medicare costs, the dramatic increases in state costs for Medicaid, the rationing approach in the state of Oregon, access for the uninsured, and the potential benefits of the financing systems of Canada, West Germany and Japan.

We all know that since 1980 costs of health care in this country have risen dramatically to over $600 billion per year. Even after adjusting for the effects of inflation during this period and considering the major cost containment activities that emerged in the '80s, costs have risen at an annual rate of over 5.4 percent per year. Despite this increase, most individuals would argue that three major problems exist in our system today, with interrelations among these three areas.

First, the health indicators of individuals in this country are not tops. Our life expectancy is lower than that of individuals in Japan, France, Germany and Canada. Also, our infant mortality rate is notoriously high, particularly among certain segments of the population.

Second, the fastest growing segment of our population, the elderly, is facing major problems with their need for long-term care and home health care services. We may be part of this group in a decade or two or three, and many of our parents are already. Of individuals reaching 65 years of age in 1990, 33 percent of men and 52 percent of women are expected to need nursing

Moderator Barbara McNeil '66 and speaker James Todd '57 talk during the morning panel discussion.

home care for some period of time; for women about 25 percent of the time the use will extend for more than five years. For all patients, the chance that the cost of nursing home care will cause them to "spend down" their assets to Medicaid levels is in the order of 25 to 38 percent.

Access is a third problem. Thirty-three million individuals—13 percent of the U.S. population—were uninsured in 1990. Most of these individuals work, and of uninsured children, most are dependents of employed parents. Only 16 percent of the total uninsured pool are nonworking adults. As might be expected, these individuals have reduced access to health care, and it appears that this reduction comes in two forms.

First, there is reduced access per se—uninsured individuals contact physicians two-thirds as often as insured individuals. Second, once in the system, their patterns of care differ from the insured. For example, in one study, Drs. Arnold Epstein and Joel Weissman in our department, and their colleagues, have shown that uninsured individuals are 50 percent less likely to have revascularization surgery for coronary heart disease.

In another study, Earl Steinberg '79 and his colleagues found that the uninsured were 29 to 75 percent less likely than privately insured patients to undergo five high cost or high discretion procedures: coronary artery bypass surgery, total knee replacement, total hip replacement, stapedectomy and correction for strabismus. Medicaid patients, despite their insurance coverage, show many of these same reduced utilization patterns.

It is clear that changes are needed in our financing and delivery system. When we think about the reason for these changes, however, it is important that we not castigate ourselves and our profession too much. Many of the problems I mentioned above—poorer health status and lower utilization rates—reflect, in part, economic conditions in society as a whole.

As part of this centennial celebration, we wanted to focus on the question of access in a special way. Thus far, there has been considerable talk about what to do. Activity in this area is speeding up as several recent events highlight:

- At its April retreat the tax-writing House Ways and Means Committee focused on health care issues.
- The House GOP Health Care Task Force has produced a bill focusing on insurance market reforms.
- Representative Russo has proposed a single-payer, national health insurance plan similar to the Canadian system.
- In an independent move, the U.S. General Accounting Office recently issued a report praising the Canadian system.
- Senator Jay Rockefeller was in New Hampshire recently trying to garner support for a presidential run. He emphasized results from the Pepper Commission, which he chaired and which recommended universal access and solutions to the problems of long-term care.
- George Mitchell sponsored a new bill that would establish a new national board, like Germany's, that would set overall spending goals and negotiate annual budgets. Like other proposals it would mandate employee coverage and include changes in the small group or small insurance market.

You can see that solutions range from a single payer national insurance plan, to expanded government programs like Medicaid and Medicare, to mandated employer-based coverage, to tax incentives, to combinations of the above. Today's symposium will delve into the access problem with an overview of the AMA's views and then a look at a subset of individuals with reduced access, that is, the homeless. □

—Barbara J. McNeil '66
Ridley Watts Professor of Health Care Policy; chair, Department of Health Care Policy, HMS

Issues in Providing 'Health Care for All'

A Proposal for Action

by James S. Todd

You can't imagine how pleased and privileged I am to participate in this timely conference addressing the changes in the health care system. It's also good to be back where it all began for me.

Giving advice is a thankless business and I want to assure you I will not venture far in that direction. Whenever I am tempted to do so, I recall a brief but profound essay on Socrates written by a small schoolgirl. "Socrates," she wrote, "was a Greek philosopher, who went around giving people good advice. They poisoned him." Although good advice is one of those insults that ought to be forgiven, I have never developed a taste for hemlock!

So I will stay away from advice and stick to my assignment here today, which is to describe the reality of reform of the U.S. health care system. The problem simply stated is that too many Americans are denied essential health care, while others perhaps receive too much care. Too many Americans slip between the web of society's safety net as the gap between the rich and the poor continues to grow. Too many of our fellow citizens are denied the benefits of health care because they cannot afford it.

One American without health insurance is unacceptable. Thirty-three million Americans without health insurance is a national disgrace. How did we arrive at this sad state of affairs?

In the 1960s it was beginning to be clear that the elderly and the poor were losing out. Over the objections of the medical profession, the government created programs to deal with these problems. Medicare was designed to provide care for the elderly; Medicaid was supposed to cover the poor. The AMA and organized medicine generally were not opposed to helping, but they were concerned that these programs did not address the related problems of quality and cost.

By the 1980s, as we predicted, inadequate financing and the inability of government to keep its commitments had pushed both programs to the brink of disaster. At the same time, business, having negotiated generous health benefits in lieu of wage increases, ran up unconscionable costs, then pulled back on its obligation to its workers. As a result, today even many people with jobs must compete for shrinking Medicaid dollars.

It is no consolation to us that many of our earlier predictions have come true. Only 40 percent of the nation's poor are eligible for Medicaid, and Medicare is headed for bankruptcy early in the next century.

In the early 1970s a report from the Brookings Institute emphasized that progress is often paired with paradox. The report said:

> All creative achievement is disruptive. Every partial solution promptly explodes open a new set of problems. The increasing application of science and technology means more frequent dislocation and more violent contradictions. It is ironic, but should not be surprising, that criticism of the medical profession and medical care institutions should develop precisely at the time when such care is better and more accessible than before.

Driven largely by costs, access has again emerged as a leading issue. It's an issue upon which both the medical and nonmedical worlds are focusing, and is shaping up to be a high priority in the 1992 presidential election and beyond. I like to think that the American Medical Association has played a major role in this turnaround.

In March of last year we unveiled our Health Access America proposal, which addresses the trio of problems: access, quality and cost. It builds on the obvious strengths of our current system, while specifically addressing the defects. It is a 16-point proposal predicated on the proposition that there is no quick fix, that everyone must be involved, that pluralism has made our country and our profession great, and that the strengths of pluralism must be preserved.

Health Access America proposes to broaden access to care by standardizing Medicaid throughout the country, so that it can fulfill its promise to cover all of the poor, not just some of the poor. Our proposal would expand employer-provided health insurance and establish state risk pools so that small businesses and uninsurable individuals can obtain coverage at affordable rates.

Ironically, our preoccupation with access and cost comes at a time when the quality of care is the finest anywhere in the world. If you've got to get sick, this is the country to be in. Yet, technology has brought us to the state where we can easily do as much harm as good to our patients and this is challenging our ability to keep pace. Ogden Nash once said that progress might have been all right once, but it has gone on far too long.

A flip remark, obviously. But doesn't it contain a seed of truth? Many of us can recall the days when there wasn't a whole lot we could do for our patients. Today the choices are virtually without limit. Knowledge changes as fast as we can absorb it and sometimes faster.

Nor has the science and the practice of medicine stood still. People are living longer, more productive lives, and the rush of technology and rising public expectations have combined to raise the cost of health care to astronomical proportions.

The fact is we can no longer do everything scientifically possible for everyone everywhere, all the time. This creates a staggering burden on today's physician, a burden that manifests itself emotionally as well as scientifically. The late Lewis Mumford, an old professor of mine, once voiced an opinion that might apply. Mumford said that in our worship of technology, "Americans have settled for something less than a full life, something that is hardly even a tenth of life or a hundredth of a life."

Interesting observation. Should we perpetuate a system that offers miraculous medical technology for some, but continues to deny even basic care to the poor and to a growing part of the middle class? Or has the time come for us to redefine medical progress, and to shift our notion of quality from doing everything possible for everyone all the time to doing what needs to be done with a reasonable expectation of benefit.

Technological feats are acceptable only when they improve a person's well-being, not when they add undesirable burdens. I believe that this is the socially responsible view not only for physicians, but also for the public at large.

Now, when we talk about access we have to define what we mean. Is the necessary health care there? Is it affordable? Can people get it regardless of their ability to pay? The dilemma now is how to increase access in an era of cost-containment.

There are two ways to do this. One is to increase revenues, including taxes, employer contributions and the individual's share of the costs. The other is to eliminate care at the margins, care

Milton Landowne '36 looks back on Alumni Day.

that is given not out of ignorance or avarice, but because of some slight possibility of benefit. The ultimate answer is probably both of the above. (Notice I did not mention budgets or expenditure caps because sick people and disease don't understand budgets.)

Recently, quality has diminished as an issue as medical education, research and technology have advanced. But medicine is changing so rapidly that physicians need help to keep up with the explosive changes in medical science and technology. Our proposal calls for the development of practice parameters, or ranges of acceptable medical management, to make sure the right care is given in the right setting and at the right time. That includes tempering scientific progress with the legitimate needs of our patients, and avoiding the temptation to do something just because it is possible.

Our proposal calls for more money from business and government, which in either case ultimately means from individual citizens. But it would also rein in costs by reforming the tort system to eliminate outlandish jury awards, thus reducing the costs of defensive medicine. It would also reduce paperwork and red tape, whether imposed by government programs or by insurers. Plus, it would increase physician accountability and reform payment methodologies. These are but a few of the common sense elements that make up Health Access America, elements based on the premise that we can strengthen the weak points in our existing system, and that we don't have to scrap the system and start all over again.

In the process we want to stop this silly debate about whether Canada's system is better than ours, or Germany's or Sweden's. They are not. Ours is a unique country and it deserves a unique solution. But if we don't concentrate on fixing the flaws in our own system, it's possible that some day those systems will by default replace ours.

Changing people's perceptions of an institution is a very difficult task, especially when many of those perceptions were formed 50 years ago. I must tell you that in a world where nothing ever stays the same, some people are still amazed when institutions once perceived as the enemies of change, rightly or wrongly, suddenly emerge as the leaders of change.

Last month, pundits and politicians alike professed shock, surprise and approval when the *Journal of the American Medical Association* called for widespread reform of the health care system to extend coverage to the uninsured and underinsured. But the fact is the American Medical Association has been trying for over a decade to cast off the reactionary image that arose from some of its past positions.

You remember in the 1930s when the *Journal* and its powerful editor Morris Fishbein, MD railed against such new innovations as group medical practices and health insurance. In the 1940s the AMA's attention was turned to President Harry Truman's call for socialized medicine. When Medicare was proposed in the '60s, the AMA opposed it for a number of reasons, including the fact that Medicare was not designed on a fiscally sound basis. We knew it was headed for bankruptcy and we said so.

But those were the old days and that was the old AMA. This is a new day. And like the television commercial that says, "This is not your father's Oldsmobile," today's AMA is not your father's AMA. We have changed, the

Dean Daniel Tosteson '48 raised his glass to toast the 400 alumni and spouses who packed Memorial Hall to celebrate the first 100 years of the Harvard Medical Alumni Association. The toast was returned. Friday evening's Gala Centennial Banquet marked the festive beginning of a new century of alumni. Soft lights illuminated the majestic rose-colored stained glass window and the busts that circle the wall. Dancing to the music of a jazz orchestra followed dinner, and many took to the floor, such as George Richardson '46 and his wife, Becky, shown here.

profession has changed, and both have changed for the better.

Today more than ever we are convinced that something needs to be done. This time, though, we are not on the defensive and we are not simply reacting to other people's initiatives. We have put forward our own aggressive proposals to strengthen our system.

The Health Access America proposal is not the only plan on the table. There are scores of others. And as we have compared our proposal with those put forward by business, labor, the Pepper Commission and others, it is clear that we are nearing a consensus.

We seem to agree that all of us—medicine, labor and business, the public, and especially our government—must throw our support behind the reform effort, and do it in a responsible fashion. Already we have cleared the biggest hurdle; we have reached a consensus on the important principle that every American has a *right* to access to decent, affordable health care. We agree, at least in principle, on the specific measures that need to be taken to reform the health care system.

We share a vision based on pluralism and private initiative, the principles that have given us the unsurpassed quality of care that most Americans already enjoy. It is a vision for improving access to health care predicated on reforming our system, not re-inventing it. Having reached this point, we are now seeking the kind of national leadership that will be needed to translate the *idea* of health care for all into the *reality* of health care for all.

It is a challenging time in which to be practicing medicine. Every breakthrough that closes one loophole has the potential to create several others. We are certainly not in danger of running out of challenges, because ours is a profession where even the successes bring us problems. It is, at the same time, both more difficult and more necessary than ever before that physicians remain at the forefront of the discussion on access to quality care and cost containment.

In these exciting and challenging times, it's no longer enough just to be a competent physician. We must be involved in the affairs of our profession. We must temper the needs of patients with the imperatives of society. Even more than owing it to ourselves and our profession, our primary debt is still to our patients.

While it has never been more difficult to be a physician, it has never been more exciting. We are on the verge of the most significant and most exciting breakthroughs in history. And so the new reality is the same as the old reality: physicians are not merely participants in their profession, they must be the architects of their profession. What we learned here at Harvard has served us well. But in order for a school to teach you everything you ever need to know, you would have to stay in school all your life.

George Reedy, the retired Neiman Professor of Journalism at Marquette University, said recently, "You are not educated because of all the stuff that's stuffed inside your head. You are educated by what you do with all that stuff." Today's physicians are presented with a unique opportunity. If we can lead the way to increase the resources available, if we can make the care we give more rational, and if we can convince everyone to shoulder their fair share of responsibility, then we will solve the problem of access.

Let me leave you with a final thought. There are those who would tell you that the golden age of medicine is gone. They dash about forming all sorts of splinter organizations because they do not believe professionalism is equal to the task. Well, don't believe them. Sure, things aren't what they used to be, but they never were. Where is it written that being a professional is meant to be easy or secure?

I believe that medicine in the 1990s will be a dynamic, maturing profession with infinite opportunities for those willing to seize them. Those who will succeed in our profession will be conscious of the judicious use of scarce resources, will cultivate patient relations, will not shrink from accountability, will not succumb to commercialism, and will remember that our prime purpose is to serve.

Whatever our frustrations and anxieties, real or imagined, let us not forget that this is the most exciting, the most exacting and the most rewarding profession there is. We should feel proud and privileged to be part of it and to work for it.

James S. Todd '57 is executive vice president of the American Medical Association.

Issues in Providing 'Health Care for All'

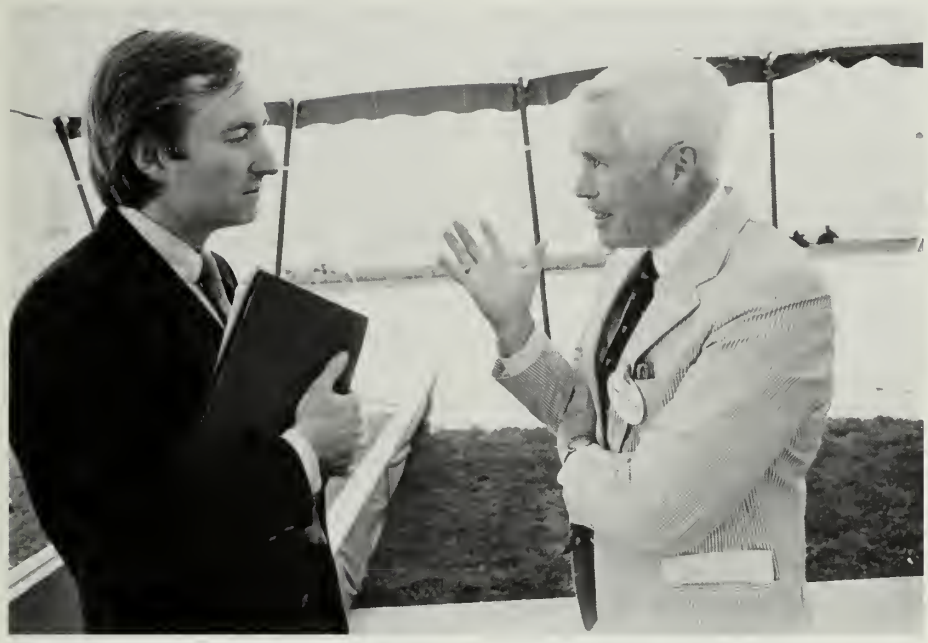
Health Care for the Homeless

by James J. O'Connell

In the fall of 1984 the Robert Wood Johnson Foundation and the Pew Memorial Trust invited major cities across the country to submit proposals for pilot programs to explore the delivery of health care services to homeless persons. Each city was required to have the support of local government, hospitals, shelters and service agencies. Boston was one of 19 cities awarded four-year demonstration grants, and the Boston Health Care for the Homeless Project (BHCHP) was conceived.

The health care of homeless persons was at best erratic at that time. The typical story now sounds almost allegorical: a kind volunteer at a soup kitchen downtown becomes concerned about progressive swelling in the legs of a woman suffering from chronic mental illness. The volunteer cajoles and pleads with her to go to the hospital, with the assistance of a cab voucher.

After negotiating the Byzantine bureaucracy of registration, the woman is appropriately triaged in the emergency room as nonacute, and waits several hours to be seen by an exhausted and overworked intern. Understandably exasperated, and distracted by the acuity of illness in other patients, the intern hurriedly exhorts her to seek



Advocate for the homeless James O'Connell '82 (left) talks with George Bernier '60.

primary care for her chronic venous stasis and hypertension, and explains that she has weeping ulcers and an early skin infection.

She is given a prescription for Dicloxacillin to be taken four times a day, and admonished to keep her legs elevated and to change the dressing three times each day. A follow-up appointment is made one week hence in the primary care clinic. The intern has precisely followed the standards of care, and the woman's fear and trepidation toward hospitals is once again affirmed.

In the early evening, five hours after registering in the emergency room, the woman leaves the hospital to return to the special problems of her situation. She has no money for the prescription, though even with access to the medication, she would have severe difficulty remembering to take the pills four times during her wanderings each day. The luxury of keeping her feet elevated or changing the bandages for her ulcers is as distant as a manicure or bathing in a tub. She would like to go to the follow-up appointment, but survival on the streets has an immediacy that preempts thoughts of tomorrow.

The hours in the emergency room have cost her a bed in the shelters, which are now full. She has missed the evening meal in the church basement, and there is no money for transportation back to the familiar blocks that encompass her daily journeys. She wanders through the night, sleeps on a park bench, and two days later she is brought back to the hospital for a 10-day admission for cellulitis of the lower extremity.

Those of you familiar with the wards of inner-city hospitals can attest to the frequency of similar stories. While the costs to the medical system are enormous, I would like to focus on one aspect of this unfortunate tragedy: namely, the pervasive sense of futility that dampens the ideals of our house staffs and sends us scurrying from the trenches.

BHCHP has been an imperfect but exhilarating attempt to address both cost and disillusion in the struggle for excellence in the delivery of health care to poor individuals and families who lack the security of a home. I appreciate this opportunity to share a few triumphs and trials with you.

The challenge was daunting, while the plan simple. In July of 1985, teams of physicians, nurse practitioners and case workers began delivering direct care services in Boston-area shelters and soup kitchens, reaching out to integrate these nontraditional clinics with the more traditional health care provided by Boston's teaching hospitals. For the better part of two years, I spent five nights a week in the nursing clinics of Pine Street Inn and Long Island Shelter (two institutions that I have come to cherish), while spending most of my days at Boston City Hospital (BCH).

I remember a man who had burned his feet on a sterno, had spent almost six months in the Brigham undergoing grafting procedures, and who later fell asleep on a December night and suffered severe frostbite to both feet. In the six months before we started at the shelter clinic, he had been admitted to the Brigham 10 times for IV antibiotics for recurrent cellulitis. His drinking assured his noncompliance with follow-up, but he would stumble religiously each night into the nurses' clinic for a footsoak and a conversation.

I abandoned the caution of my training and began a one-a-day antibiotic as soon as an early erythema arose in an open area of his skin grafts. He never stopped drinking, yet he was not admitted again to the hospital, until three years later when he developed metastatic lung cancer.

Similar stories are legion. I treated a presumed fungal rash on the leg of a 30-year-old man at Pine Street Inn one evening, and he returned with worsening symptoms one week later. After confessing a measure of inepititude in dermatology, I offered to facilitate an appointment in the dermatology clinic at MGH the next morning. He politely declined, pointing out that he had to be in the day labor pool office by 6:00 am and that he would lose his entire day's wages if he went to his appointment.

Since I could not find a dermatology clinic on evenings or weekends, he agreed to let me take a picture of the rash. I was duly chastised by my dermatology friends for not recognizing chronic lichen planus. With the appropriate medication he was better within two weeks, and he has been one of my most devoted patients ever since.

In the fall of 1986 I referred a man to BCH for admission for a lower extremity cellulitis and a 102-degree fever. The intern was splendid and caring, but in the sobering light of morning our patient pulled out his IVs and headed for the package store. During the subsequent week, our clinicians attempted to admit him on two other occasions, but with similar results.

We succumbed to reality and stored doses of Nafcillin at key mileposts along his daily trek. On most days, he received early morning and late night IM doses in the Pine Street Inn nurses' clinic, and another dose at our clinic at St. Francis House—a soup kitchen and day center in the Combat Zone where he ate lunch. We left the other dose in the refrigerator of a local tavern, and the bartender (who also kept insulin for

another patient of ours) would call our nurse practitioner when the man arrived late each afternoon. His fevers defervesced, and the leg was back to normal in two weeks.

I offer these examples rather sheepishly and humbly, for practicality has often finessed our traditional treatment plans and forced us to meet the special needs of a transient and impoverished

George Mendelsohn and Michael Marmor '66

population. The flexibility and creativity required for the care of our patients have led to the evolution of an accessible network of health care and social services. In 1990 BHCHP cared for almost 7,000 individuals in 28,000 visits. We have grown to include 34 full- and part-time staff, with a budget of almost $2 million.

Seven physicians work in teams with seven nurses and several case workers, and primary care clinics for homeless persons are held four times a week at BCH and twice a week at MGH. Direct care services are offered at 46 sites in the greater Boston area, including adult and family shelters, shelters for battered women, soup kitchens and day centers, hotels and motels. A patient's chart at BCH will contain the record of visits to any of the 46 sites, minimizing duplication of services and facilitating communication among providers.

All homeless persons admitted to Boston City and Mass. General are visited at least twice each week by our teams, allowing us to work with the house staff, continuing care nurses and social workers to arrive at practical discharge and follow-up plans. Our 25-bed Medical Respite Unit in the Shattuck Shelter has been the barter with which we push for better care; residents on the wards know that we will accept homeless persons who are ready for discharge but not ready for the rigors of survival on the streets. In exchange, persons referred from our clinics are more willingly admitted with the knowledge that disposition is not a problem.

To pay our medical school loans and the exorbitant Boston rents, our physicians have consciously chosen moonlighting jobs in jails, detoxification units and methadone clinics—all of which have expanded the network of services available to our patients. Our entire staff meets twice each week for case presentations and didactic sessions.

Let me highlight several other aspects of our unique service delivery model. Bicultural and bilingual services are available for Latino patients, and one-half of our clinicians are persons of color. Our two dentists—both of whom were Robert Wood Johnson fellows at the Harvard School of Dental Medicine—provide comprehensive dental services with fully portable equipment at St. Francis House. Only dentures are beyond our capacity at this time.

Boston is blessed with several small and superb family shelters, many of which offer supportive environments and a host of needed services. Our family team visits these shelters each week or two, providing episodic care as well as education and prevention. Because most families identify a neighborhood health center as a primary care site, we work to facilitate appointments to preserve continuity of care whenever possible. Our mission is not to establish an alternative system of care for homeless persons, but to make the established care system more sensitive to the special needs of this population.

When the family shelters are full (capacity is about 125 families, with an average stay of two to three months), the remaining families are uprooted from neighborhood and community supports and placed in a welfare hotel in Boston's theatre district, or in one of several motels from Peabody to Hull. Our nurses visit each site regularly.

In stark contrast to those in family shelters, these parents have little support. They must care for their children in a sparse room without refrigeration or cooking facilities, often far from supermarkets and public transportation, and usually in an area ravaged by drugs and prostitution. (We solicited a grant from the Mazon Foundation to supply refrigerators to the rooms in Boston's welfare hotel for medication and perishable foods.) Nowhere is the tragedy of homelessness and poverty more evident than in the hopelessness of these single mothers in sparse motel rooms, in the midst of the vibrancy and exhilaration of their children.

Our public health nurse specializes in the management and prevention of communicable diseases in the shelters. A comprehensive immunization program was organized with the assistance of the Massachusetts League of Neighborhood Health Centers, and virtually all of the children living in shelters have been immunized.

Boston's dismal infant mortality statistics were clearly no surprise to our clinicians. One of our nurses and a family advocate work with the Healthy Baby program to engage homeless women in early prenatal care. Of the first 15 women followed by our nurse and the family advocate in 1990, all delivered babies of normal birthweight. This triumph was shortlived, however: three of these babies died before the age of six months. We then realized that avoiding low birthweight is barely the beginning of the services needed by these mothers and children.

AIDS has undoubtedly been the greatest stress in the evolution of the BHCHP. Frankly, I was surprised to find only one known person with AIDS in Boston's shelters when I began in the summer of 1985. Within a year, I had 13 newly-diagnosed AIDS patients, most of whom were persons of color whose risk behavior was intravenous drug use. We have since cared for 75 persons with frank AIDS, and over 400 persons with known HIV infection at various stages.

To assure excellence in the care we provide to these patients, three of our physicians and two nurse practioners conduct weekly sessions in the AIDS clinic at BCH. Our providers there are thus able to follow their patients in the shelter clinics, minimizing the costly use of specialty clinics while learning to adapt to the needs of persons with HIV infection living in shelters and on the streets. In addition, they have been able to hone their skills in this ever-changing specialty, while teaching the rest of our staff about currently avail-

able protocols and medications. Many of our patients, despite their often-chaotic living situations, are compliant with AZT, DDI and aerosolized pentamidine and all are offered enrollment in appropriate experimental protocols.

While I could speak at length about the effects of AIDS on our program, let me simply point out the painstaking amount of time that each provider spends with an AIDS patient. I remember comfortably caring for 15 to 20 homeless persons during a clinic session at Pine Street Inn in the winter of 1985/86. Most persons suffered from respiratory illnesses and the effects of chronic alcohol abuse, and the diagnosis was ordinarily quite straightforward.

On evenings in the clinic now, the evaluation of an IV drug user who comes with a fever requires easily an hour of time, severely limiting the number of persons seen each night. This wreaks havoc when reporting to the public funding sources on programs such as ours.

Finally, allow me to shift focus somewhat in describing our Medical Respite Unit. This unit was conceived as an infirmary for persons ready for discharge from acute care hospitals to a stable living situation, with the supports of a visiting nurse or home health aide, but not yet able to withstand the vicissitudes of survival on the streets. Located within the Lemuel Shattuck Shelter in Franklin Park, this 25-bed unit is staffed by one of our teams, which includes a physician, nurse manager, staff nurse, case worker and three aides.

Since 1985, over 1,000 persons have been admitted, with median stays of three weeks. Referrals have come from virtually every hospital in the area. About 20 to 30 percent of our patients are admitted with HIV-related illness. An array of services are offered, including physical therapy, occupational and expressive therapy, podiatry and dental services, substance abuse treatment and counseling, AA and NA meetings, literacy classes and support groups. Our social worker investigates all possible entitlements for each patient, and fully 25 percent of our patients are discharged to housing or rehabilitation programs.

We believe that we offer far more comprehensive care to persons convalescing in the Respite Unit than they receive in an acute care setting, and at a fraction of the cost. In addition, we have the capacity to divert hospital admissions for homeless persons who present to the local EWs with illnesses such as diabetes, uncomplicated pneumonia and cellulitis.

The demand for these beds is quite intense, as the unit is at 120 percent capacity, and we have to refuse more than half the calls we currently receive. We are anxious to move to an independent site away from the shelter to double our capacity. We have the doctors and nurses necessary to provide 24-hour staffing, and we're now searching for a suitable building.

Yet for the past three years we have struggled to make sense of the payment system in our country, as we naively thought that the compelling logic of such dramatic cost savings would assure reimbursement from some existing funding stream. Twenty-five percent of our patients have Medicaid/SSI, 25 percent General Relief from Massachusetts, and 50 percent are without insurance. Current Medicaid rules do not recognize this type of facility; we have worked with state officials at the Department of Medical Securities (which administers the fee care pool) as well as the Department of Public Welfare (which manages General Relief and Medicaid), and there was genuine hope for optimism prior to the current fiscal crisis. We will continue to pursue this dream despite the dire economy.

The success of the BHCHP is due to the expertise and commitment of the staff. I could not agree more with Robert Goldwyn's comment in the spring issue of the *Bulletin*: "Medicine in general and HMS in particular will ultimately depend for its quality upon those who choose to follow in the pathway of Hippocrates." When I reflect on the nine doctors who have taken full-time positions with us during these past six years, three are HMS graduates, while three were trained at MGH, one at BWH, three at BCH. They are among the best of our young physicians, and I rage about the sacrifices they make because of our inability to pay competitive salaries.

Our population is extraordinarily ill, and the medicine utterly fascinating, and I firmly believe that this work is important and should not become the domain of zealots or saints. I also rage about the uncertainty of public funding, and I understand how easy it is for programs such as ours to fail. How can we recruit new residents in November for positions the following July when our budget for January is unknown or uncertain?

Excellence in the delivery of care to the poor and indigent is a proud legacy that has flourished in the teaching hospitals, in harmony with the daunting accomplishments of our Nobel laureates. I believe that this tradition remains very much alive in programs such as ours and many others across the country. I would implore your blessing, especially amidst the escalating economic and social complexities which our students and residents face. I know that our program has succeeded in large part because of the support and genuine enthusiasm of Deans Tosteson and Federman here at HMS, John Noble and Sandy Lamb at BCH, and

George Saxton '46 and his wife, Anne

especially John Potts, John Stoeckle and Al Mulley at MGH.

We are only as good as the people who choose to work with us, and we collectively are the ones who help to shape the vision of our students, much as these physicians have shaped mine. Students and residents from all of Boston's hospitals and medical schools have done rotations with us, enriching our lives and keeping us sharp. In fact, four of our full-time physicians accepted positions after working with us as residents, after I spent almost two years working as the sole doctor because we could not find anyone interested in the other positions.

So, as you can easily surmise, I am both pragmatist and idealist—probably reminiscent of my errant years as a bartender and erstwhile philosopher. I struggle with that tension.

I leave you with these final but incomplete thoughts. The care of the poor in our society is costly and often second-rate. I submit that addressing this urgent issue in American medicine requires every bit of the hard work and brilliance that have always been the hallmarks of this Quadrangle. It is perhaps no less complex a problem than unraveling the mysteries of the cell.

Just as AIDS has obscured the boundaries between specialties such as oncology and infectious diseases, the care of the poor requires a dissolution of the boundaries between medicine and society. The appropriate care of our woman with lower extremity cellulitis involved more than the diagnosis and correct prescription, and without the involvement of nursing, social service, entitlements and housing, the physician's efforts were in vain.

We will need the best and brightest physicians in the future to be willing to share their expertise with those concerned with housing, education, job training, day care, correction, business, legal aid and a host of other agencies. Our first timid forays in to such a netherworld have proven most exciting, but we have a long way to go before society embraces our poorest citizens and eliminates the barriers to full participation in the American dream.

James J. O'Connell '82 is executive director of the Boston Health Care for the Homeless Program. He is also program director of the Homeless Families Program, Robert Wood Johnson Foundation and HUD.

Professional Liability and Intrusion of Third Parties

The impetus to poll Harvard Medical School graduates about their affection and disaffection for their profession came from conversations Bob Goldwyn '56 had several years ago with Boston colleagues distressed by the changing character of our profession.

Physicians in the Bay State had become increasingly restive by the

mid-1980s, feeling themselves the victims of big government and big law. Bob brought the substance of these conversations to the Alumni Council. To explore whether the issues were local—a preoccupation of Massachusetts and New York practitioners—national or universal, and how many issues there were, became the rationale for the alumni survey.

That the disaffection of physicians has become universal, however, can be documented by an examination of the literature of disaffection that appeared between 1984 and 1991, and comparing it with that of the previous two decades.

In the period 1966 to 1985 the cross-referencing of the terms physician and satisfaction/dissatisfaction in the medical literature deals almost exclusively with the satisfaction or dissatisfaction of patients with their doctors. Of 1,445 references, only five are concerned with physicians' dissatisfaction with what they are doing professionally.

The literature of discontent emerges in 1984, when cross-referencing the terms physicians and dissatisfaction yields 21 papers chronicling the unhappiness of doctors.

The message is played out in the titles of these papers:

"How Satisfying is the Practice of Internal Medicine? A National Survey" (Ann Int. Med. 114:1, 1991),

"Job and Life Satisfaction among Rural Physicians" (Minn Med 72:215, 1989),

"Mental Health, Job Satisfaction and Job Stress among General Practitioners" (Brit Med J 298:366, 1989),

"Sued and Nonsued Physicians. Satisfaction, Dissatisfactions, and Sources of Stress" (Psychosomatics 28:462, 1987), (In case you wondered, sued physicians are more dissatisfied.)

"Burnout among (CMHC) Psychiatrists and the Struggle to Survive" (Hosp Community Psychiatry 38:843, 1987),

"Job Satisfaction for Women Physicians" (J Am Med Wom Assoc 42:57, 1987).

Not to mention:

"Physician Satisfaction in a Major Chain of Investor-Owned Walk-In Centers" (Health Care Manage Rev 15:47, 1990) and

"Burnout and Its Causes in Finnish Dentists" (Community Dent Oral Epidemiol 18:208, 1990) or

"Sources of Satisfaction and Stress among Canadian Physicians" (Psychol Rep 67:1335, 1990).

Editorial writers joined the chorus with pieces entitled:

"The Fun Days are Gone" (J Ky Med Assoc 88:559, 1990),

"Unhappiness in Medicine" (Pharos 53:48, 1990),

"Medicine's Winter of Discontent" (Pharos 53:41, 1990),

"Dispirited Doctors" (Postgrad Med 82:168, 1987) and

"From Arrowsmith to *The House of God*, or 'Why Now?'" (Am J Med 88:449, 1990).

One wee voice asked, "Are We to Blame for Our Own Unhappiness with Medicine?" (Tex Med 85:4, 1989), but, in what John Taylor has recently called our "culture of victimization" (New York, June 3, 1991, p.26), it is not very acceptable to assume personal responsibility for anything bad that happens to us.

The data of discontent, sometimes flawed by small cohort size and biased question-asking, comes from health professionals in Arizona, District of Columbia, Massachusetts, Minnesota, New Mexico, New York, Pennsylvania, Washington, Canada (particularly, Ontario), England, Finland and Japan. Their themes are refrains: loss of autonomy/loss of control over clinical decision-making (the specter of the third party), the threat of malpractice litigation, the imposition of administrative burdens, and too little income or the threat of reductions in income through governmental fiat.

There are cohort-specific dissatisfactions, such as loss of collegial interactions among physicians who work in freestanding walk-in clinics, the failure of generalists to be acknowledged as specialists, complaints from emergency physicians that excessive time has to be spent with patients' families, complaints from adolescent medicine physicians that they have too little time to spend with patients' families and, of course, there is the complaint of back pain among Finnish dentists. (I am also sorry to report that by the end of each working day, one-third of Finnish dentists indicate they don't care greatly what happens to their patients.)

Two other themes that recur in the literature of medical discontent are reassuring and were detected in the only surveys that permitted doctors to express positive feelings about the profession. First, the articulation of complaints about the current *practice of medicine* does not, in the majority of physicians, gainsay a persisting sense of satisfaction with the *discipline of medicine*, nor with the doctor/patient relationship, in which both patient and doctor have sensible degrees of autonomy. The Harvard survey, therefore, is not unique in detecting a high level of satisfaction with the medical profession, as well as conveying a litany of concerns about the regulation of practice.

The second recurring theme is unease among physicians about the lack of access to health care for the uninsured in American society and a feeling that doctors must take an initiative in dealing with this problem.

Is the literature of discontent unique to medicine? Are other professions afflicted?

I am indebted to Dean Martin Belsky of the Albany Law School for the following information. Major surveys of lawyers conducted in the past five years indicate that fewer than 50 percent of lawyers are satisfied with the practice of their profession. Approximately one-third of polled law school graduates have no association with the legal profession.

Nonetheless, there has been a 25 percent increase in the number of applicants to law school in the past five years and apparently an increasing use of the law degree as a springboard for careers in business. I should also point out that the reason most frequently cited by practicing lawyers for their dissatisfaction with their calling is "the failure of society to understand the legal profession."

Returning to a consideration of medicine, the cataloguing of discontent in medicine in the past half-dozen years is a relatively empty, albeit cathartic, process until and unless we propose realistic solutions. The advocacy of solutions is part of the job of the next panel. We will consider the subject of malpractice litigation and the policing and disciplining of the profession.

— Paul J. Davis '63
Professor and chairman, Department of Medicine, Albany Medical College.

Professional Liability and Intrusion of Third Parties

Redressing the Wounds of Liability

by Barry M. Manuel

Recent surveys of the American College of Surgeons, the American Medical Association, and numerous state medical societies reveal that professional liability and the "hassle factor" caused by the intrusion of third parties into the practice of medicine are the two most significant problems facing physicians today. I shall discuss professional liability and how this problem will be addressed in the future.

In the early 1970s we experienced the first modern-day crisis in professional liability. It occurred when a group of insurance company actuaries realized that they had overlooked a significant increase in the frequency and severity of professional liability claims during the preceding few years. When the magnitude of this oversight was recognized, a number of commercial insurers dropped the product altogether. Those that remained charged premiums that were frequently unaffordable by physicians. This created a crisis in the availability of professional liability insurance.

In response to that crisis, all 50 states passed legislation, and over 300 different statutes were enacted—but that response proved to be inadequate. A review of the frequency of professional liability claims since 1976

reveals a significant upward progression until mid-1989, when the number of claims filed flattened and then decreased.

Recent statistics indicate that this trend has been reversed, and that the frequency of claims is now rising again. At the same time, average medical malpractice verdicts have continued to escalate, approaching an average of $1.2 million in 1990. Professional liability premiums have also escalated significantly—estimated to have approached $5.5 billion in 1990.

From these statistics, it is easy to recognize that we have not yet solved our professional liability problem. Some of the reasons for this are as follows:

- Malpractice screening panels have not proved to be effective: either they have been found to be unconstitutional, such as in Florida, Illinois and Missouri; or they have been repealed—Nevada, North Dakota and Rhode Island; or, as in other states such as Massachusetts, they have been essentially rendered ineffective by legal interpretation or decision.

- Lawyers have discovered the fertile field of birth defects and the enormous awards associated with them. There is also an increasing tendency for the courts to assign liability to obstetricians in cases of defective births.

- Punitive damages are being assessed. Punitive charges are criminal charges and one cannot purchase insurance against punitive damages. The way this has played out is that a physician first learns that he/she is being sued. Shortly after reporting this to his/her insurance carrier, a representative of the carrier comes and tries to assuage some of the physician's anxiety by discussing the case. However, the representative mentions that the physician must obtain his/her own counsel for punitive damages, since the malpractice carrier does not cover those.

A week or so later, the physician gets a call from the plaintiff's attorney, who apologizes for having asked for punitive damages and suggests that he will drop the punitive damages if the defendant-physician gets his/her insurance carrier to settle the case.

It is one thing for physicians who feel they are being wrongly sued for malpractice and wish to defend themselves knowing full well that the credit and financial resources of a large insurance company are behind them. It is quite another when physicians have to defend themselves against punitive damages, where all their personal resources are at risk.

- Change in statute of limitations from the time of occurrence to time of discovery.

- Countersuits by physicians have been overturned by superior courts, and the United States Supreme Court has refused to hear any of the appeals.

- Increased publicity over large settlements. This tends to increase the demands made by plaintiffs and also tends to force more cases to the courtroom, where juries tend to be very generous.

- Increased marketing and advertising by malpractice plaintiff attorneys. I am sure you are all aware of the ads in newspapers and on television that exhort people who have had, or think they have had, a bad medical result to contact a malpractice attorney for a free consultation.

- Attorneys are becoming more sophisticated and specialized, i.e., a neurosurgeon who has become a plaintiff's attorney and now specializes in children who have suffered brain damage at birth.

- Hedonistic damages are now being awarded. Over 23 states now recognize hedonistic damages, and the awards in death cases have risen to the millions of dollars.

- Awards associated with HIV-contaminated blood do not portend well for the future. To the best of my knowledge, only one case of professional liability associated with transfusion-related AIDS has made its way through all the appeals process. In that case, in Arizona, the jury awarded a plaintiff over $28 million, which on appeal was settled for over $6 million.

It is estimated that there were 30,000 units of blood tranfused in the United States between 1980 and 1985, before a commercial test became available to identify the HIV virus. At the present time there are over 300 AIDS suits pending in the United States.

If $6+ million proves to be the floor for malpractice awards in cases of HIV infection, secondary to blood transfusion, the future could look very dim indeed. Compare this to the Republic of Germany, which settled a number of transfusion-related HIV infection cases for approximately $50,000 per case, and the United Kingdom, where over 1,700 transfusion-related AIDS cases were settled for an average payment of $16,000.

- Professional plaintiff's physicians. This is a particularly noxious group of our colleagues who testify many times each year. They do not limit themselves to one state, but travel throughout the United States peddling their so-called expertise. Some of these professional plaintiff's physicians are full professors at prestigious institutions.

From my perspective, professional liability does not belong in the courts for several reasons. The physician is not tried by a jury of his peers. Despite good intentions, most jurors understand very little about the practice of medicine, and cannot comprehend the complex issues involved in professional liability. Juries tend to be emotionally vulnerable to severely injured, handicapped or suffering plaintiffs, which can interfere with their ability to be objective. The fine line between professional liability and maloccurrence is one that even trained experts have difficulty distinguishing.

Due to prolonged litigation, delays in compensation can also cause undue hardship to the truly injured plaintiff. Costs of the current system are excessive and account for 75 percent of the professional liability premium with only 25 percent going to the injured patient.

The present system can cause great

injury to the physician, his/her family, reputation and practice. Rarely is the damage reversible, even if the physician is fully exonerated.

Sarah Charles, an academic psychiatrist at the University of Illinois, researched the psychological effects on physicians who were sued for medical malpractice in Cook County, Illinois. Her findings at the time were surprising even to those of us who were familiar with the emotional damage caused by professional liability.

Charles found 39 percent of physicians who were sued suffered four or five symptoms suggestive of a major

depressive disorder, and 20 percent acknowledged another group of symptoms, including anger, change in mood, inner tension, frustration, irritability, insomnia, fatigue and headache. Eight percent noticed the onset of physical illness, of which 2 percent had a myocardial infarction during the process.

Over half, 56.5 percent, felt they and their families had suffered as a result of the suit, almost 19 percent felt a "loss of nerve in some clinical situations," and one-third said they had contemplated retirement as a result of the suit.

These findings are all the more disturbing when one realizes that 75 percent of the physicians surveyed by Charles were later acquitted and yet suffered significant emotional damage. It is the litigation process itself that is so devastating.

If, however, we are to come up with a solution to professional liability, we must expand our thinking beyond the negative effects that this current system has on doctors to the effects professional liability is having on our entire health care system. Indeed, professional liability is having a significant negative effect on the access, quality and cost of health care.

In terms of access, an excellent study done by the Institute of Medicine, published in the *New England Journal of Medicine*, reported that access to obstetrical care is being negatively affected by our current system of professional liability, especially to economically disadvantaged women. (The report also mentioned that the doctor/patient relationship is also being harmed.) I believe that similar studies of other high-risk specialties, such as neurosurgery, orthopedics and emergency room medicine would yield identical findings.

The quality of health care is also being affected. Vincent T. DeVita, former director of the National Cancer Institute, reported at an annual meeting of the American Cancer Society that the number of cancer victims who die as a result of less than optimal drug treatment (under-treatment) may number 10,000 or more annually: "Malpractice is behind it in part. Doctors are frightened to death of malpractice," DeVita said.

At the same meeting, William Hryniuk of the Ontario Cancer Foundation stated, "Doctors tend to undertreat in this country [the United States] because they fear complications will lead to a lawsuit. People are suing themselves into second-class medicine by pursuing this mentality. They are binding their physicians' hands."

A survey by the American College of Surgeons revealed that 40 percent of its members are not accepting high-risk cases, and 28 percent are not performing certain procedures, solely because of the fear of a malpractice suit. If 40 percent of the most highly qualified surgeons are not seeing high-risk cases and 28 percent are not performing certain procedures, then who is, and at what cost to the quality of our health care?

We have problems in obstetrics, where one in eight obstetricians has given up obstetrics and where the rate of Caesarean section is estimated at over 29 percent. Of the obstetricians who have given up practice, surveys of the American College of Obstetrics and Gynecology indicate that they are doing so at a progressively younger age. In 1990, 54 percent of the obstetricians who gave up obstetrics did so before 45 years of age, and 67 percent before age 55.

We can better understand this when we look at the number of times obstetricians are sued. The same survey by the American College of Obstetrics and Gynecology reveals that 70.6 percent of obstetricians have been sued at least once, and 25.5 percent have been sued three or more times. The average professional liability premium of an obstetrician/gynecologist has gone from $10,946 in 1982 to $38,138 in 1990.

The rate of Caesarean section remains a worrisome by-product of our liability system. In the early 1970s the rate of Caesarean section in the United States hovered just below 6 percent of all births, similar to that of the rest of the free world. That figure now exceeds 29 percent in the United States, though in the rest of the free world it has remained below 6 percent. The reason, I suggest, is because our system of professional liability places the blame for every "bad baby" in the laps of obstetricians and consequently forces them to go to Caesarean section at the first indication of any difficulty —and far sooner than clinical judgment would otherwise dictate.

The final issue is the cost of health care. Professional liability premiums are approaching $5.5 billion per year, but in my opinion that pales next to the cost of defensive medicine. The cost of defensive medicine is very difficult to quantify and has been estimated anywhere from 15 percent of the cost of physician services to 30 percent of the cost of health care. I feel that the cost of true defensive medicine is approximately 20 percent of the cost of health care, a very significant sum indeed.

In May 1991, President George Bush submitted to Congress the "Health Care Liability Reform and Quality of Care Improvement Act of 1991." The bill encourages states to adopt within three years quality assurance measures, tort reforms, and alternative dispute resolution mechanisms.

The quality assurance measures call for improving quality and reducing the incidence of negligence. Who can argue with either? One must realize, however, that the quality of health care in this country is superior, and probably as good as if not better than anywhere in the world. A recent Harvard study on professional liability indicated that the incidence of negligence in New York hospitals was approximately 1 percent. The converse of this would indicate that 99 percent of acutely ill patients treated in New York hospitals were treated without negligence.

The president's tort reforms also include a reasonable cap on noneconomic damages, the elimination of joint and several liability, the prohibition of double recoveries by plaintiffs, and they permit health care providers to pay damages for future costs periodically, rather than in a lump sum.

I personally was disappointed in this part of the act because it is similar to the tort reform enacted in the mid-1970s, which has proven to be unsuccessful.

I feel the solution lies in the third part of the president's package—alternative forms of dispute resolution. The mechanisms most frequently mentioned are arbitration, administrative alternatives, contractual limitations of medical practice liability, early tender offer, fault-based administrative models and, my choice, patient compensation (no-fault) plans.

Arbitration may be either voluntary or mandatory. Under a voluntary program, the patient who has suffered a maloccurrence may elect to enter arbitration or sue through the tort system. The arbitration process can be binding or nonbinding. In binding arbitration, the decision of the arbitrator is binding on all parties. In nonbinding arbitration, either party may choose to ignore the decision and proceed through the tort system. The scope of arbitration can be all inclusive or limited to certain types of cases, i.e., neurologically damaged newborns, failure to diagnose, lack of informed consent, etc.

The advantages of arbitration are the use of knowledgeable and experienced arbitrators as opposed to unsophisticated emotional juries. The arbitration process should significantly reduce overhead costs, including attorney fees, and reduce the time it takes for the patient to receive compensation.

A disadvantage of arbitration is that arbitrators tend to compromise more frequently than juries and also tend to be quite generous toward plaintiffs.

Mediation has proven somewhat effective in health care disputes but not in professional liability. For mediation to be successful, it requires both parties to agree. In the case of professional liability, there is usually so much anger and hostility that it is difficult to reach an amicable agreement between the two parties.

The use of **private contracts** between parties for dispute resolution and risk allocation is another possible approach to solving our current problem. Attempts to implement this plan in the past by medical care providers have usually been struck down by the courts as violating public policy. However, pretreatment contracts between patients and physicians might be used to alter the standard of care by defining the physician's duty to perform as a "reasonable and prudent physician." Because of the growth of managed care programs and concern about the cost of health care, cost-effectiveness might be included in this definition.

Another contractual approach might seek to define the credentials for expert witnesses or mandate the use of impartial experts. Still another contractual option might redefine liability, using gross negligence rather than ordinary negligence as the standard.

While contractual limitations have some promise, one wonders whether the time, uncertainty, and the cost of proceeding through the court system in order to defend the constitutional challenges that are certain to occur might make this approach impractical, too time-consuming and too costly.

We also have the **"early tender offer"** suggested by Virginia Law School Professor Jeffrey O'Connell. Under this proposed law, the alleged perpetrator of a tort would have the option of offering to pay the claimant's net economic loss, in periodic payments as incurred. If a defendant made this offer, the claimant would, in most cases, be forced to accept it, and would be foreclosed from further pursuit of a tort claim. The settlement offer, to be binding, would have to cover all medical expenses (including rehabilitation) and wage losses not already covered by "collateral sources" like health or disability insurance.

Although a definite improvement over our current method, this solution would create a whole new set of issues for the practicing physician. Physicians would have to decide whether they were a "perpetrator of a tort" or if the incident was a maloccurrence. If it were a maloccurrence, would the next step be a potential court trial with the accompanying publicity and emotional trauma to the physician and his or her

Parvin Saidi '56 comments on the problematic bureaucracy of applying for government funding for health care programs.

family? Would the physician wish to risk a career and financial future on the ability of a lay jury to understand a complex medical case? Finally, if the physician offers to settle the claim, what penalties will the professional liability insurer, the Board of Registration and the National Practitioner Data Bank impose? It is likely that these uncertainties could prevent this type of solution from being universally adopted and applied by physicians.

There are many other suggested **fault-based models,** including the Pennsylvania Claims Resolution Procedure, the Medical Accident Compensation System, the Physician Insurers Association of America Proposal and the American Medical Association/ Subspecialty Society Medical Liability Project: Administrative Dispute Resolution System. In my opinion, any system that retains the concept of fault will continue to perpetuate the enormous cost of defensive medicine, take a significant emotional toll on physicians, and have a negative effect on access and quality of health care.

In order to have a satisfactory solution that will address the above issues, we must have a mechanism for ensuring like compensation for like injuries, and we must spread the cost over all those at risk. For many years, I have favored a patient insurance, or **no-fault plan.**

In return for waiving tort claims, the patient could receive compensation for a maloccurrence without having to prove the physician was at fault. This approach would ensure legitimate claimants prompt compensation for injuries resulting from medical maloccurrences.

This plan would be voluntary. A patient could elect to use the tort system to obtain relief. However, because clear parameters for compensation would have been established, it would be unlikely that the courts would significantly exceed the awards of the commission. In addition, the patient who elected to pursue the tort route would face a 20 percent chance of success, since defendant physicians prevail 80 percent of the time in court trials. Also, the patient would lose over 40 percent of the court award to fees and expenses, and might have to wait up to seven years for resolution of the claim. Clearly, there would be significant incentives for the patient to accept fair compensatory awards rather than pursue tort action.

A corporation would have to be created for the purpose of administering the system of compensation benefits for compensable medical injuries. Most likely, it would be governed by a board of directors appointed by the state's governor, and would be composed principally of physicians, insurers and consumers.

A compensable medical injury would be defined as any illness, injury, impairment or death that was the result of an act or failure to act by a health care provider during the course of medical examination or intervention; was not within the reasonable range of medical outcomes that may have occurred as a result of a condition; or was not, but reasonably should have been, discovered in the course of a medical examination. Medical injuries caused primarily by a defective drug or device used in medical examination or intervention, or those intentionally inflicted would be excluded.

Patients could file their own claims or physicians and/or hospitals could file claims on behalf of their patients. Lawyers might represent patients before the commission, although their fees would be statutorily set, thus eliminating a contingency fee. The commission would award net economic loss only and structure payouts for losses stretching over more than 90 days.

No compensation benefits would be paid to any claimant with respect to pain and suffering, mental anguish, punitive or exemplary damages, or all other general (as distinguished from special) damages, including loss of any of the following: consortium, society, companionship, control, protection, marital care, attention, advice, counsel, training, guidance and education.

A subcommittee of the commission would investigate hospitals or physicians who experience repeated claims. Working in cooperation with the State Board of Registration and medical specialty societies, this board could arrange for education, retraining or disciplinary action for physicians whose practice was found to be substandard.

A further advantage of the no-fault approach is that it would provide the medical profession and the public with comprehensive information about poor results and errors in medical practice. This information could be used to identify physician outliers, as well as to compare diagnostic and treatment methods.

Funding for a patient compensation (no-fault) plan could be achieved in a variety of ways, as long as it included all individuals at risk. For example, the program could be funded by a surcharge on every health and accident policy sold; a tax on all employers and self-employed persons; a surcharge on state and federal income tax; or general revenues of state and federal governments. I personally favor a surcharge on every major medical health and accident policy, but clearly a patient compensation system that covers all medical maloccurences cannot be funded solely by physicians, who constitute less than 0.2 percent of the population.

Since more patients would receive compensation under this plan, a major concern is whether the cost would exceed that of our present system. For several reasons, I feel the answer is no. Overhead would be reduced significantly, from over 50 percent to less than 10 percent, leaving far more money to be redirected to patients. Only economic losses would be covered, and the enormous cost of defensive medicine would be reduced substantially. A recent Harvard University Medical-Practice Study of more than 30,000 patients revealed that a no-fault system would cost no more than our current system.

The only ones who would suffer from such a change would be the small number of malpractice attorneys. Currently, these lawyers receive over one-half of the premiums physicians pay for professional liability insurance.

Professional liability continues to be one of the two most severe problems facing practicing physicians today, and it is adversely affecting the access, quality and cost of health care in the United States. The current system is unfair, untimely, inefficient and does not benefit those for whom it was intended. Remedial legislation is not the answer. We must have a major change in our tort system that removes the entire process from the courtroom, and so covers all maloccurrences by an alternative form of dispute resolution plan before any further damage occurs to the quality of our health care and the physicians who provide it.

Barry M. Manuel, MD is associate dean and professor of surgery at Boston University School of Medicine, and is immediate past president of the Massachusetts Medical Society.

Professional Liability and Intrusion of Third Parties

Destruction of the Temple

by Harvey Klein

My good friend Pepper Davis has again entrapped me into yet another Alumni Day talk. At first he said that *any* topic would be welcome. But, after he had me on the hook, he quickly rejected a well-seasoned, canned talk on "Towards Modern Computer Design of the Truss." Because of my intense interest in health care reform, I next suggested a talk entitled "Lessons From Abroad—a comparative analysis of the health care systems of Qatar and Liechtenstein." This too was nixed.

Instead, Dr. Davis insisted that I address the issue of the loss of luster of the profession due to hassle, stress and intrusion of the third parties into practice. Now, I practice medicine in Manhattan—admittedly an odd thing to do. I do so in an office behind the gift shop of a teaching hospital and, despite being so close to the stuffed animals and the Snickers bars, I really do practice.

As a practitioner, I could devote the whole afternoon to a laundry list of outrages. I could entertain you with a rousing indictment of the yearly congressional circus called "Blaming the doctors for Medicare." (After all, what kind of lowlife makes a living by taking money from the sick?) I could elicit knowing nods by railing against the receipt of letters that address me as "Dear Provider," which lump me together with nebulizer salesmen and purveyors of easy lifting chairs. I could go on about having to sign innumerable attestation forms that threaten jail terms for perjury or just inadvertence. But I won't because those of you who pursue the noble calling of the private practice of medicine know all of this only too well.

Instead I wish to tell a cautionary tale and offer a bit of a solution. I will concern myself with the arcane process of physician discipline in my state.

The state of New York, through the Department of Health (DOH), has developed the most comprehensive system of regulation of physicians and hospitals in the country. Through its single-payer DRG system, it controls the entire operating income stream of hospitals, and through its huge corps of inspectors, it regularly issues new regulations and conducts minute reviews of every aspect of hospital service. For violations it levies substantial fines and issues derogatory press releases. Depending on your point of view, this is either good activist public policy or quintessentially overbearing intrusiveness.

Certainly this micromanagement of all hospital service, revenue and decision-making has spawned a large regulatory bureaucracy in Albany and, in accordance with Newton's third law of medical regulation, an equally huge, expensive corps of hospital executives to insure compliance on the other end. Despite all of this, my own observation is that patient care is no better or worse than it ever was.

One certain change, however, is that administration, nurses, and doctors at all levels of training spend less time actually taking care of patients and more time documenting what they do. For example, the legal staff of my hospital has developed a seven-part form for "DNR Documentation," which covers sixteen sheets of paper and is preceded by an eight-page instruction manual. All this must be completed before one can write an order to withhold a worthless therapy from a terminally ill patient.

Our form is considered a model of its kind and is universally admired. Administrators from other hospitals regularly come to gaze in wonder at our DNR form, with the same intensity and awe as young sculptors in the Michelangelo sacristy of the Medici Church in Florence.

The DOH, naturally, also regulates physician conduct. The term is, of course, a misnomer; what the DOH does is ferret out and punish *misconduct*. Until recently, few of us worried about this, believing that if we weren't alcoholics, drug addicts, thieves, rapists, assassins or insurance fraud artists that we were immune from this process. Good doctors had nothing to fear. How naive we were!

Discipline is in the hands of the state health department's Office of Professional Medical Conduct (OPMC), which is directed by state attorneys, staffed largely by retired policemen, and utilizes a hearing committee with both lay and medical representation directed by an administrative law judge. Any complaint—phoned, written, faxed, signed or anonymous—is investigated. In addition, under the Public Health Law,

Carl Walter '32 (left) and Claude Welch.

malpractice carriers must report all claims to OPMC, whose investigators routinely collaborate with the plaintiff's attorneys.

Practicing physicians in New York now consider the process so suspect, mean-spirited and threatening that the state medical society now offers a *separate insurance policy,* distinct from malpractice, to cover some of the costs of retaining a lawyer to represent the physician during an OPMC investigation. The academic physician is not immune; at least one major university medical center in New York City also offers legal services insurance for OPMC representation to members of its faculty practice plan.

It comes as no surprise that there are now attorneys who specialize in OPMC defense. The OPMC, however, automatically suspects any physician who refuses to deal with it without counsel. In the old wild West, this was called a "Mexican standoff." Experienced lawyers advise you not to talk to these folks without counsel; the investigators then assume they are on to something and that the doctor must be guilty of something really bad.

Clearly the OPMC is not the doctor's friend; its effectiveness is measured by the number of people it hangs every year—not by the number of complaints investigated and dismissed. We have worried for years about malpractice, which after all is only about money, premiums and pride. I now ask you all to consider the latest manifestation of "medico phobia": the disciplinary process as a reincarnation of the Holy Inquisition.

I wish to discuss some aspects of this process as it unfolded in the now celebrated Libby Zion case.

In brief, an 18-year-old woman, who had been under treatment with several psychiatric drugs, was admitted to the New York Hospital late on a Sunday evening in March 1984. She complained of a week of fever and pharyngitis following a tooth extraction. No specific localizing findings were found on examination, and the patient exhibited intermittent episodes of severe restlessness and thrashing about, which appeared to be under volitional control.

A diagnosis of viral illness with hysterical symptoms was made by the ER resident, the assistant resident on the medical floor, and the intern. The attending physician, who had not seen the patient for two years, was kept informed by phone and was to see her early the next morning. Because of her bouts of agitation, the patient was sedated and restrained, and she appeared stable and calm for several hours.

Harrison Black '43B waits behind Seebert Goldowsky '32 to direct a question to the panelists, while Wesley Furste '41 listens.

Early in the morning, however, she was found to have a temperature of 42 degrees Celsius, and shortly thereafter she had a cardiac arrest and died. Despite multiple, exhaustive reviews of the clinical data and an autopsy by the medical examiner, the cause of her death remains unknown.

The patient's father is a prominent journalist and a former reporter for the *New York Times,* with substantial influence with the press and local politicians. Consequently, press coverage was extensive, strident, unremitting and sharply critical. A perception that fatal errors were made by the house staff because of prolonged working hours became widely accepted, even though all three of the house officers involved had been on duty since only that morning.

The district attorney of New York County convened a grand jury in April 1986, which concluded that there was insufficient evidence upon which to base a *criminal indictment!* Nevertheless, despite no cause having been established for the patient's death, the grand jury concluded that medically deficient care and treatment had been rendered. The report recommended legislative and administrative actions to limit house staff working hours, control the use of physical restraints in hospitals, and to provide contemporaneous supervision of house staff by attending physicians at *all times* and at *all hours.*

Next the OPMC came into the picture and charged the intern and the resident with 38 acts of gross negligence or gross incompetence. Between April 1987 and January 1989 the two residents attended 30 hearings, at which 33 prominent medical witnesses testified. Almost 5,000 pages of testimony were generated. The verdict of the hearing committee was unanimous; none of the charges of professional misconduct was sustained by the evidence. The Commissioner of Health agreed.

But, unfortunately, the final review body, the New York State Board of Regents—composed entirely of politically appointed laymen, acting under intense political pressure to "look tough"—voted last year to censure and reprimand both residents. The matter of this capricious action by the regents is now being challenged in the courts.

I will not go into the enormous psychological and professional damage done to the two young residents. Suffice it to say that in my view it is shameful. The cost thus far to the hospital for legal representation for these two house officers exceeds $1 million.

The whole affair sends a message to young students considering residencies in New York State: if it even appears that you might have made a mistake on an influential patient, your career can be destroyed. A paper in the August

1991 *Annals of Internal Medicine* by Norton Spritz, MD brilliantly examines these issues, and I urge everyone to read it carefully.

The attending was also charged and a separate series of hearings were held. He was cleared of all charges by a first panel, but a second panel was convened when the state was able to find another "expert" to condemn the attending's conduct. (Because these are administrative rather than judicial hearings, the state can convene as many panels as it likes.) Between November 1987 and May 1989, the attending was present at 22 full days of hearings, at which 17 medical witnesses testified. There were over 3,000 pages of testimony and the legal costs to this physician alone were over $350,000—not covered by any insurance policy, but paid out-of-pocket.

Just six weeks ago, seven years after the patient's death, the attending finally received his final verdict from the regents. He has been exonerated on all counts.

This attending physician is my colleague and my friend. He is an internist and nephrologist who cares for some of the sickest patients around. We were on the house staff together and I have always admired the knowledgeable, thoughtful, well-balanced and compulsive way he goes about being a physician. His ordeal lasted seven years and cost him not only his savings for legal fees, but also time lost from his practice and his life.

I can assure you that the strain and humiliation of these prolonged hearings have taken their toll. It is dreadfully unfair to treat any human being as he has been treated, let alone a well-trained, highly respected, hard-working and caring doctor with a spotless 30-year record.

What happened to this doctor could happen to any of us—our Harvard degrees and any professional eminence notwithstanding. His whole life was at stake for seven years because of a medical judgment made on the telephone. This doctor, like so many other doctors in New York state, was charged with *misconduct* as a result of *misdiagnosis*. And, despite ultimate exoneration, was severely and cruelly punished—the process itself was the punishment.

It is clear to those of us who have followed this case closely that the usual investigatory process was magnified, inflated and perverted because of political pressure brought to bear by the patient's influential father. Any politically appointed body is subject to pressure and manipulation from the media and elected officials. Both of these groups were very active in this case.

We are entitled to better than this. There must be reform. Certainly each state should have a mechanism for investigating and disciplining medical practitioners. But, as Dr. Spritz so elegantly points out, the process must be equitable: influenced only by objective analysis, without undo delay, and subject to expert input throughout the process.

This may be a good time for change in New York. The state is heavily in deficit. It is said that funding for the DOH may be cut by as much as 15 percent this year. In addition, a new commissioner of health will soon be chosen. I propose that a consortium of the medical colleges of New York take over the physician disciplinary process under an experimental contract. The membership of this newly constituted board would be nominated by the dean of each institution from the ranks of the clinical faculty of each school. In this manner the members would be insulated from political pressures, and be truly expert and in full control of the entire investigatory and disciplinary process. I believe it is right and proper that the institutions charged with the education and advancement of the profession also be responsible for defining and judging misconduct.

This proposal is subject to criticism by a public that does not trust the "medical establishment" to police itself. I submit that the nominated faculty would be representative of the most expert and admired segment of the profession, and, coming from the universities, would be less suspect than physicians coming from the medical societies. We should ask to be given this chance. The current system is expensive, cumbersome, tortuous and unfair; it can be done cheaper, quicker, fairer and better.

As a patient of mine says, "What is hot in New York on Monday turns up in the shopping malls of Grand Rapids on Thursday." Ladies and gentleman, beware!

Harvey Klein '63 is William S. Paley Professor of Clinical Medicine, Cornell University School of Medicine.

SUMMARY

A philosophical question is: how educable do we think that people in the legislature might be? That question has a narrow applicability to malpractice, but it has a far broader applicability to society as a whole. If those people are not capable in some way, we've got a far bigger problem than the one about malpractice . . .

Seems to me we can rationalize both what we learned through the survey and what we heard in the symposium. It is a fabulous privilege to be a doctor and to be an educator or an alumnus of a medical school but there are lots of problems, and lots of things to work on. As I thought of it from the school's point of view, in the past we were lucky enough to attract today's speakers, and all of you as students. In running the school now, our biggest hope is to be lucky enough to attract the same kind of people for another hundred or more years.

—DANIEL D. FEDERMAN '53

Patient Philosophy

Putting Principles Into Practice

by Mitchell Elkind

Although four years had passed since I last looked at my undergraduate philosophy thesis, I recently pulled it out of the back of my filing cabinet, having been inspired by a symposium at HMS on Class Day entitled, "Science, Ethics, and the Future of Practice." The symposium, held on the occasion of the 100th anniversary of the HMS Alumni Association, considered the relationship between the rapid development of science and medical technology and the ethical issues that this progress engenders.

Beginning the day-long series of lectures and panel discussions, Herbert Hechtman '60, David Cullen and Robert Demling discussed basic science and ethical issues of critical care medicine. Some recent advances in our understanding of the genetic bases of idiopathic hypertrophic subaortic sclerosis and the thalassemias were then addressed by Christine Seidman and Stuart Orkin '71, respectively, while Genetics Department Chairman Philip Leder '60 provided a glimpse into the implications of the "New Genetics."

Neuroscientists David Potter and Huntington Potter next spoke about drug addiction and Alzheimer's disease, in a session moderated by Gerald Fischbach, chairman of neurobiology. Finally, Lynn Peterson, Peter Black and Ned Cassem '66 provided their views on the nature of medical ethics in more general terms.

The entire series of lectures—and in particular those about the nature of medical ethics as an enterprise in itself—got me thinking about the thesis I had written (and then hidden away) several years ago on the American pragmatist John Dewey. I had taken immediately to Dewey's criticism of the traditional philosophical approach to problems as conflicts between essentially opposite points of view: the dichotomy, for instance, between those who thought that "reality" rests "out there" somewhere, independent of the thoughts of human beings; and those who argued that "reality" is simply a construct of the human mind. Dewey's philosophy seemed to offer a way to bridge the gap between the so-called realists and idealists; it also emphasized science, rationalism and empiricism.

My plan had been to extend Dewey's thoughts about morality to the area of medical ethics. Because I intended to go to medical school, I also hoped applying his philosophy to the realm of medical ethics would enable me to bridge my own gap between being a college philosopher and a future medical student.

Unfortunately, I recalled after retrieving it from the drawer, my thesis had been a flop. Dewey's philosophy, while offering a useful general approach to ethical problems, didn't seem to have anything especially interesting to say about medical issues, particularly the issues that have recently grabbed the attention of the public: the right to die, use of fetal tissue for research and transplantation, distribution of resources and the need for rationing. Because of his insistence on the importance of individual circumstances in the analysis of any ethical dilemma, and his abhorrence of moral absolutes, I was unable to truly apply his philosophy to any particular medical ethical problems.

I agreed with his approach, but it didn't leave much room for argument outside the context of any particular situation. While his is a good and sound medical approach, it didn't offer a neophyte philosopher a whole lot of thesis material. So I floundered and flailed in several directions before settling on a fairly simplistic account of his views, and a fairly direct application of his writings to medical ethics in a broad sense.

I defended, as I thought he would have, some general principles: patient autonomy, a flexible conception of "health" that would differ within the context of different patients' lives, and the importance of communication between medical professionals and patients. I was glad that I had chosen to write about Dewey and medicine because it gave me the opportunity to dive into medical ethics, which I knew would be useful later, even if I wasn't able to adapt Dewey perfectly to the topic.

Of course, part of the reason Dewey's philosophy had so little to say to me about medical ethics was related to the fact that I myself knew so little about medicine at the time. While I realize that I am still only at the beginning of my medical education, returning to my thesis now has allowed me to reconsider what I'd thought then in the light of three intervening years of medical school. While my feelings about the general principles I'd argued for in that paper haven't really changed, I've come to understand in a deeper, more concrete way, what I believed then.

In such an ethic, physicians-in-training would acquire their moral sensibility by observing their mentors in action and emulating them, rather than by discussion of abstract principles.

This contrast between the abstract and concrete aspects of medical ethics was addressed at the alumni symposium by Peter Black, chief of neurosurgery at the Brigham, in his discussion of approaches to medical ethics. He argued for a medical ethic based on virtue rather than principles. In such an ethic, for instance, physicians-in-training would acquire their moral sensibility by observing their mentors in action and emulating them, rather than by discussion of abstract principles. In such a conception, the emphasis is placed on the

agent of moral acts, rather than on the acts themselves.

Morality is judged, moreover, not simply by any one particular situation, but by the aggregate of situations over a long period of time. Physicians would, in effect, attempt to act virtuously over the long haul, rather than try to conform their thought and action to some set of particular rules governing situations.

While I think there is much that is worthwhile in such a conception of ethics, it also leaves much unsaid about just what virtue is supposed to be. How are we to recognize virtue, one might wonder (as Socrates surely would have). This is where a principles-based theory of ethics becomes useful, for it attempts to spell out exactly what it is about any particular person's thoughts and actions that drives us to call him or her "virtuous." The principles-based theory falls short, however, exactly where I fell short in my application of Dewey to medical ethics: the principles are not the practice. One needs an understanding of medicine in practice in order to truly appreciate the significance of the principles.

From a Deweyan point of view, of course, the division of morality into virtue-based or principles-based appears artificial. Obviously we need a combination of both: we want physicians who are "virtuous"—skilled, honest, caring, thoughtful, etc.—and we want to be able to explain our actions on the basis of certain rational principles, which are subject to discussion and clarification.

In a sense we are caught in a tight circle: the advantage of the virtue approach is the way in which it brings the seemingly abstract ethical principles down to earth, embodying them in people and physicians we admire, creating our role models. At the same time, a principles approach allows us to render less abstract the notion of "virtue" itself, for it can tell us what it is about the thoughts and actions of our role models that makes them appear virtuous to us. Virtue and principles are, therefore, interdependent, mutually supportive, and equally necessary.

At a more personal level, my medical education has itself been a way of bringing together those abstract principles to which I subscribed as a philosophy student, and the concrete realities of medical practice within which every physician attempts to achieve virtue. It was easy for me to think abstractly about such issues as patient autonomy and rationing of medical resources, for instance, as a student of philosophy. But it required experiences with real patients to clarify—by either challenging or reinforcing my college student's thoughts—the meaning of my faithful pragmatist's position.

Dewey, for example, had argued against intellectual or other absolutisim; I understood this as an abhorrence of hierarchy, authoritarianism, paternalism. He argued that the resolution of every problem rests in discussion, attention to the facts, consideration of all angles—a working through of the problem from the bottom up, so to speak. I took this to indicate a concern for patients' rights to decide for themselves.

One encounter on the wards this year particularly confronted my notion of the principle of patient autonomy. The patient was an elderly man with multiple medical problems, including diabetes, chronic heart and renal failure, and peripheral vascular disease. He had bounced back and forth between the medical and surgical services for several months as he underwent successive amputations of his lower limbs.

When I met him he was actually quite comfortable, not in any pain, not short of breath; mostly he complained of being tired of the hospital, and in particular of the air mattress, which had become like a prison for him. The team, however, recognizing the precariousness of his situation, decided that the time had come to discuss his status.

In attending rounds that morning, the senior resident asked me what I thought we should do. Thinking of my commitment to the "principles" to which I had subscribed as a philosopher several years earlier, I said that I thought the matter should be left up to the patient. We should, I said, explain the issues to him, describe what it would mean to be on a ventilator, the possibility that he might not come off of it, and then allow him to decide.

My resident laughed—and disagreed. Although he admitted to agreeing with me "in theory," he also felt that there was little chance we could explain in any meaningful way just what being on a ventilator was like to someone who hadn't experienced it. We had a responsibility to the patient to ensure that he receive whatever care we thought best for him. Because we all agreed, given his grim prognosis, that DNR status would be best, we should explain his situation and options in such a way that he would want to sign a DNR agreement. While I agreed that DNR status probably was the best option for him, I still couldn't help feeling that this decision ultimately belonged to the patient.

My intern and I went to speak to the man. He was frightened when we talked about respirators and the possibility of cardiopulmonary arrest; we were "bringing death to him." As our resident had suggested, however, we convinced him that it would be best if there were a DNR order in the chart. We thought he understood all we said, and that our DNR order reflected his wishes.

The following day, however, he angrily called me into his room as I passed. He had changed his mind, he shouted at me; he wanted the machines, the ventilator, everything. He had spoken to a friend who apparently convinced him that such life-prolonging measures were only temporary. He was horribly afraid of dying, and suggested that we might be trying to hasten his death. I reassured him and promised him we'd return later to discuss his decision further; I needed to talk more with the team.

I have often wondered what would have happened—or really, how I would have felt—if my patient had arrested later that day, before we'd had a chance to talk with him again. True, there would have been a DNR order on the books, but was this really what the patient wanted, or simply what we felt, knew, or wanted him to want? How fully did he understand what we were trying to explain to him? Could he have understood us in the midst of all that fear of death?

For me the real question is, I suppose, to what extent could he be considered a participant in the rational discourse that marks the Deweyan process of problem resolution? Can patients in times of duress be expected to act or think with full rationality? Are *they* themselves—never mind their surrogates!—fair representatives for themselves? Or perhaps it had been we who had unfairly explained the situation to him. Maybe he was only now expressing his true desires. Had he been misled or even deceived by us on the previous day?

All these questions threw a glitch into my neat conception of Deweyan ethics and patient autonomy. Clearly

there was something else going on here that I hadn't fully taken account of earlier. Of course, I had realized while writing my thesis that there were some peculiarities of the physician/patient relationship that made a strictly Deweyan approach problematic. I had even written a paragraph or two about how the fact of illness changed the problem-solving dynamic in the physician/patient encounter from that of any other interpersonal interaction.

I am certain I will continue to bridge the gap between the abstract and concrete, the philosophical and the medical, throughout my career as a physician.

I had never, however, truly appreciated the obstacles to full autonomy: a patient whose fear and distrust make completely rational decision-making impossible, and our limited ability as physicians to allay anxiety or communicate facts and opinions fully. Now, face to face with a situation in which the possibility of autonomy was in question, I became aware of the limits of my abstract philosophical principles in real medical practice. While I still don't doubt that patient autonomy is an ideal principle upon which to base medical ethical decisions, I have come to realize, through experiences like this, how challenging it will be for me to put these principles into practice.

Rationing of medical resources was another topic discussed at the symposium, the significance of which became much clearer to me after working with patients. Many have condemned the wastefulness of a medical system that spends an enormous fraction of its resources on keeping people alive for a few extra weeks at the end of their lives. Obviously, we would like to offer unlimited medical care to everyone in society; given the fact of limited medical resources, though, it seems reasonable to reduce resources given to a subset of the population that can least benefit from them. In effect, as Cullen stated in his lecture, we need to ration intensive medical care, using as a partial standard the likelihood of a patient's recovery.

While this argument made sense to me even before I went to medical school, spending the summer between my first and second year of medical school in the Dominican Republic reinforced this feeling in, again, a more concrete fashion. While there, I worked in a rural health clinic in a mountainous region called Yabonico.

A half-hour ride down a bumpy dirt road separated the village from the rest of the country, and the poverty—even in this generally poor country—was remarkable. There was no electricity or running water, and deforestation and drought had left much of the land infertile. People grew edible plants on small plots of land next to their homes, saving the better soil for growing tobacco to be sold to cigarette factories. Despite their poverty, however, the people were extremely generous, warm and friendly. One woman, who lived high up in the mountains, insisted on serving me a breakfast of eggs, onions and moldy bread, though it meant her own family would have no egg that day.

The medical clinic itself was small and severely understocked. The staff comprised two doctors who had just completed medical school the year before. Once a month a government pick-up truck came rumbling down the road from the highway, carrying drugs for the clinic. Word of its arrival would get around, and the following morning a long line would form at the clinic gates.

The Dominican physicians and I were constantly frustrated by the lack of both medical supplies and general resources. I saw a three-year-old girl with severe asthma die for lack of medication. Another little girl with severe dehydration from diarrhea nearly died because her parents had been giving her an herbal tea that acted as a laxative—the result of inadequate education. Malnutrition was rampant, and I saw my first case of kwashiorkor in the home of a family that lived by the side of the road without any land of their own.

Since living in the Dominican countryside I have viewed modern American tertiary care medicine with some skepticism. The transition from the tragedies of scarcity, which I encountered there, to the tragedies of plenty, which I soon discovered in our intensive care units here, struck me with its full ironic force. The fact that the situations I found in Yabonico exist throughout the world, and within the cities and rural areas of the United States, only intensifies this irony.

Although much of the tragedy of poverty is well outside the scope of medicine proper, a more rational distribution of medical resources could go a long way toward helping resolve some of these unfortunate disparities in health. Again, while the importance of a rational—and rationing—approach to the distribution of health care was obvious to me, the immediacy and power of witnessing the Dominicans succumb to curable illnesses because of their poverty made infinitely more tangible the significance of this philosophical point. The abstract was made concrete in an extremely powerful, painful way.

I am certain I will continue to bridge the gap between the abstract and concrete, the philosophical and the medical, throughout my career as a physician—every time the exigencies of real life intrude upon the neat and logical world I dream up. Sometimes, no doubt, there will be conflict between my conception of how things ought to be and how they actually are, as there was when my notion of patient autonomy faced the challenging limitations imposed by disease, communication and hospital practice.

At other times, my beliefs may be powerfully fortified by experience, as my belief in a more rational and equitable distribution of resources was strengthened by what I saw and felt in the Dominican Republic. In the shifting interplay between the abstract and the concrete—between principles and virtuous practice—lies the elusive truth about medical ethics.

Divorced from practical experience, my philosopher's approach to medical ethics had to be a flop. Rereading my thesis now, I realize that is indeed what John Dewey was trying to tell me all along. □

Mitchell Elkind is starting his fourth year at Harvard Medical School. He majored in philosophy at Harvard College and then spent a year at Cambridge University studying philosophy of science.

REUNION REPORTS

60th Reunion

The road from medical school graduation to our 60th reunion has been all too short. Filled with rewards, disappointments and some detours—too many of our classmates could not make this, our last reunion.

Approximately 20 ambulatory survivors made it to our opening luncheon, initiating the first of a series of events celebrating the Harvard Medical School Alumni Association's centenary. George Sturgis and the alumni office prepared the 60th reunion report containing biographical material on members of our own class and on the surviving members of the classes of 1919 through 1930. Members of the class who had died during the past were remembered.

A class survey identified medical costs, ethical considerations, and the doctor/patient relationship as some of the most pressing problems facing our profession today.

The highlight of our celebration was a fascinating address by Joe Murray '43B, who reviewed the history and selecting process of the Nobel Prize committee. His pictures of the ceremony were of special interest.

Sherry and a full stomach added to our contentment as we warmed ourselves in the reflected glow of Joe Murray's many awards and accomplishments, topped off by receiving the Nobel Prize in Physiology. We left well aware of the tremendous contribution that HMS has made to our collective lives.

—George R. Dunlop '31

1931

57th Reunion

At our 55th reunion two years ago the attending members, noting the ascending rate of morbidity and mortality of our age, voted to have a mini-reunion midway before the final scheduled pentad. The centenary celebration of the HMS Alumni Association this year provided a special attraction and choice. A three-day program was arranged for the period of June 6 through 8.

Nineteen of the surviving 56 members attended the gathering for most of the activities, which began with the full day of symposia and a pleasant lunch in the atrium of the education building on June 6. That evening 33 attended dinner at the Harvard Club, finding the Esterbrook Room an ideal location for that group of classmates, spouses and guests. Friday's beautiful weather and the fine centennial program washed away memories of the cold and wet experience of our 55th reunion. Because almost half of the group had problems of locomotion (without ataxia) the "decision difficult" was made and instead of the gala dinner in Cambridge we settled for a quiet evening at the Countway Library. This was pleasantly preceded by the reception and display of the delightful collection of prints, paintings and books of Robert N. Ganz '24 and his wife, Claire M., in the Atrium of L1 of the Countway. After dinner in the Minot Room, each returnee had an opportunity to tell some experience or memory he had of our four years. Zinsser was most often cited in the preclinical years, and Minot and Castle for the clinical period. Midmorning on Saturday began with tours of the Medical Education Center and the newly renovated Vanderbilt Hall, guided by an able, verbal member of the Class of 1994. During our lunch in the Commons Room, Yvonne

1934

Geeve, director of Vanderbilt, fed us facts and figures of life there today—a contrast of interest and thought from those we had experienced our first years of medical training. The mini was a success.

—Thomas A. Warthin '34

55th Reunion

Of our class, 21 members and their wives joined for all or part of the festivities, and we were especially pleased to have the widows of four other classmates also with us. All but two of this group were on deck at The Country Club (of Brookline) on Thursday evening to greet each other and to hear Paul Russell tell us about the decades of progress in transplantation, in which he himself has had such a key role. His talk was effectively and excitingly pitched to the meager understanding his audience had of the relevant basic facts. The Friday evening Gala Centennial Banquet's numerous happy features were marred by the auditory pollution of incessant ultra-amplified sounds from the orchestra, which almost precluded conversation. It left many of us converted to membership in SPAMAB, the Society for the Prevention of Amplified Music at Banquets. On Saturday 20 of us heard a superbly organized, informed, fully illustrated summary of the architectural history of Boston by the architect A. Anthony Tappe. We then had a tour by motor coach he planned to show us the structures he had described in his talk. A leisurely lunch at the Museum of Fine Arts was followed by a one-hour, carefully selected, tutored stroll through some of the more intriguing exhibits. Those of us who attended these 55th reunion events were impressed, among other features, by our good fortune in surviving in good enough health to be there.

—William H. Sweet '36

50th Reunion

From the opening festive salvo at the house of Perry and Kits Culver on June 5, through symposia, lectures, tours, class dinner at The Country Club, commencement, the bicentennial banquet of the Alumni Association at Memorial Hall, then Alumni Day and finally a mid-day pool party and clambake at our house in Manchester on June 8, the Class of 1941 was busy, interested, convivial and nostalgically reminiscent. Forty-five members came—half of all the living—plus 36 wives and one widow.

Our reunion gift to the school—from 81 percent of the living members—amounted to $123,400.00, a record for a 50-year class. Alfred Pope successfully, tactfully and perseveringly led his team of agents through this exercise with a minimum of fuss.

The positive features were the weather, the solidarity and the mutual admiration. We were unhappy that one member had to withdraw at the last minute because of illness, and the wife of another broke her hip—at HMS!—

1936

1941

on the first day of the reunion.

The Class of 1941 entered in a great depression and then a war. Things have come full circle, but we continue the common threads of caring—for our families, our patients, our school, our friends and our profession. It was a great re-affirmation.

—Curtis Prout '41

45th Reunion

Our 45th brought us good fellowship, good weather, and a chance to catch up with elapsed time. Enough of us were assembled from all over to supply at least a little information about the too-many who could not attend. The main occasions went as planned: scientific symposia on the newly reconstituted Quadrangle (there's a parking lot under it now), dinner for the class at the Tavern Club; the HMS Centennial Gala Banquet at Memorial Hall in Cambridge (which featured, but probably did not welcome, some loud renditions of songs about other colleges led by Jeff Freymann and Dave Solomon); and a mid-day clambake by the sea at George and Becky Richardson's house in Nahant.

Our Nobelists were feted by special observances at HMS—once again, for the record, we are the only HMS class to boast two winners of the Nobel Prize, Carl Gajdusek and Donnall Thomas.

The figures gathered for our reunion report show that half of us are retired or semi-retired while half are still active. Since a number of classmates are in geriatrics, or in closely related fields, it would seem to be a good idea to have a just-for-us seminar on aging at our 50th—informally, with comments or rebuttals from the assembled consumers, male and female.

Reunions bring together a too-small, self-selected group, and inevitably the number of those available falls through illness and death. Ever hopeful, I expect that the 50th will stimulate an unprecedented percentage of us to head for Boston and HMS. I urge each classmate, starting now, to proselytize the friends they most missed at this reunion, find out why they couldn't make it, institute remedies, and wind them up generally to attend our next—health permitting, of course.

—George Richardson '46

40th Reunion

June 6 heralded the 40th reunion of the Class of 1951. Registration was in Building A, followed by a gourmet luncheon in the atrium and a dramatization during our excellent seminar on estate planning.

We followed this with a seminar on neurobiology in an elegantly appointed lecture hall, where we sat on uphol-

1946

stered seats—far different from our post-prandial respites 40 years ago in the soporific lectures of bygone days. Drs. Fishbach and Potter lectured on new insights in cocaine addiction and Alzheimer's disease.

Thursday evening the class visited the home of Gerry and Ruth Foster, where the theme of the evening proved to be "Who did you used to be?" Ruthie was a gracious hostess, providing a bountiful table and libations.

From Puerto Rico came Michael and Cuca Woodbury, with offspring. From Washington state came the Skinners and the Kleavelands; from California, the Faheys, the Dick Jones and the Wheelers; the Lou Krakauers from Oregon; the George Plums from Texas; the Bob Moores from Nebraska; the Bill Danforths from Missouri; John Stetson from Chicago; President and Mrs. Elbert Tuttle from Georgia; the Zukowskis from Arizona; Tom Haymond from West Virginia; George "Ramrod" Summer from North Carolina; Will Fernald from Ohio; the Walt Haynes and the Vic Curtins from Florida; the Tor Richters from Pittsburgh; and finally, closer to home, the David Bikoffs, Ned Wilmers, Bob Davises, Clem Hieberts, Bob Arnsteins, Jim Fields, Jerry Fischbeins, Ruth Weiss and Herb, Jock Robey, Bob and Betsey Reid, Ed and Ellen Bell, Helen Hess, the Tom Peebles, the Art Cains and Art Ellison. Apologies to others I did not see.

Carol and Lou Krakauer spoke of seeing George "Bird" Murphy, who has returned from Alaska and is practicing in Oregon. On the Fosters' couch were the Dick Galdstons reminiscing with Jock Robey, and Bob and Betsy Reid. My old floormate Hal May told me he was working at the Brigham. Bob Olson spoke at length on the carotenes and other antioxidants, debunking some of the popular ideas, as he had on radio.

After a few trips to the old yearbook, we finally straightened out who was Dick Jones (Wil was in absentia). We partied into the wee hours of the early evening, and split before midnight.

Friday featured Alumni Day and an interesting questionnaire, a spirited affair with discussion and riposte. Bob Oates was convinced that he could have increased the endowment fund by an investment strategy, but no one answered his letter. Dean Tosteson introduced our heroes, Nobelists E. Donnall Thomas '46 and Joe Murray '43B to the rising ovation of the audience.

We adjourned to the far end of the tent and supped in gourmand fashion (in contrast to our fare in leaner years). But missing were the familiar figures of prior reunions: the lean, gaunt figure of Bill Castle; the wild plaid vest of Sam Epstein; and our absent classmates—the animated wit of Norm Geschwind, my old pal Rance Arthur, Uncle Al Damon, and all the others.

We repaired to the steps of Building A, where we all smiled on cue for a color photograph. After this, Bob Reid and I decided to view the refurbished Vanderbilt Hall. On entering the door the eyes are dazzled by polished brass mailboxes—culture shock. In the courtyard, Preston Clements from Florida reminded us of the famous bonfire in the tennis court around 1950 (which I did not recall, though Bob did), a remnant of more high-spirited times.

Dave and Fran Richardson from Virginia apparently joined the group for the Centennial Dinner Dance—a delightful affair.

Saturday noon found us on the Rhode Island shore at the Weekapaug Inn. The high quality of the weekend cuisine was maintained by a delicious luncheon, after which we sauntered down to the beach led by our hostess, Ruth Foster, who educated us on the local vegetation we passed. Completely covered by a high-numbered sunscreen, Rae and I goggled at the integumentary surface of classmates and wives basking in the solar blast furnace.

We returned to the Inn for dinner, which we shared with the Watsons, the Fields and the Woodburys. Oliver Wendell Holmes would have agreed that two of Harvard's strengths are comradeship and conversation worth CME credits. John Fahey spoke of his work in immunology in California, while Lou Krakauer told about his battle with the post-polio syndrome and his enthusiasm for Deprenyl. Michael Woodbury spoke about zombies and the sociopolitical and economic nuances of this ritual.

After dinner Elbert Tuttle rose and announced that he was abdicating the class presidency. He nominated Gerry Foster, who has labored as class agent for these many years. Foster rose as if to accept this high honor to the applause of his classmates, but then renounced the award. Inspired by a former patient, he said he renounced the presidency and declared himself "Emperor for Life." We are probably the only Harvard Medical class to be led by a duly elected emperor. The Class of 1951 has come a long way in 40 years.

Someone suggested that in future years the mates of deceased classmates be extended a formal invitation to reunions. This was warmly received.

Walt Haynes rose and announced that he had brought a video of the late Norman Geschwind that Paul Watson had made and it was available for viewing in the TV room.

The remainder of the evening was filled with jokes, anecdotes and good fellowship. Al Skinner presented me with the provincial "East of Dedham Award," a T-shirt depicting Longwood Avenue (properly) as the center of the universe. It made my celebrated xenophobia seem worthwhile. I wore that shirt proudly for the next two days.

There had been a wedding at the Inn. We adjourned to the parlor where I found an upright Mason and Hamlin piano (my brand). I started to play and the father of the bride began a singalong. Joined by the rousing voices of the Skinners, Richters and others, we played the night away.

As we adjourned for the evening we paused with Dick and Sally Kleaveland and Al Novick. Al told us about his extraordinary work with IV-drug users and the AIDS population. He also discussed his well-attended undergraduate course at Yale in social ethics. We were fascinated and reluctantly went off to bed, passing Bob Oates, nattily attired in his surgical greens, rapping with Lou Krakauer in the video room.

After breakfast I joined the distinguished company of President Bush and King Hussein in a one-and-a-half hour bout of arrhythmia, thus proving "we got rhythm" (albeit erratic) and so ended the year "that Yaffee got atrial fibrillation."

And thus ended the 40th reunion of the Class of 1951. Looking back, Al Skinner noted that it is improbable that many of this motley crew would be admitted to the HMS of today. Derek Bok reached a similar conclusion after testing the current law boards. Each man for his time. There really is something special about renewal at HMS. It really is bigger than all of us.

See you all in 1996. Can you imagine our 50th in 2001 . . . mind blowing.

—Howard S. Yaffee '51

1956

35th Reunion

A brief note to bring you up to date on the reunion activities of the Class of 1956 from HMS. We had our class dinner on Thursday night at the downtown Harvard Club, with approximately 70 people in attendance. We had a delightful meal and a wonderful reunion.

Many of the class members attended the two-day symposium at the medical school and a large number, in the range of 60 people total, attended the Alumni Dinner held at Memorial Hall in Cambridge. This was a delightful event and I think it was enjoyed by all.

On Saturday morning, about 30 stalwarts flew down to the Ocean Edge Resort in Brewster, Massachusetts on Cape Cod and had a delightful weekend at this facility. It is truly a remarkable place with a long beach front, many tennis courts, which were put to good use, and a delightful golf course, which was the site of an epic reunion golf match with Drs. Brochin, Reigh, Barbarisi and me. I strongly recommend this facility for class reunions as they did a first class job.

In summary we had a thoroughly delightful reunion and I think that all who made the effort to attend were delighted that they had.

—Richard S. O'Hara '56

30th Reunion

The reception at Vanderbilt Hall common room: faces have grown older—except for a few extraordinary fountains of youth, but the spirits are still there, amazing in their freshness. Handshakes, hugs, grins of recognition. Memories come flooding back. Our teachers and mentors, Drs. Jessiman, Davis, Murray, Walter, Barger helped us recall those terrified days when we felt we had to know everything lest we reveal we knew nothing.

Saturday's outing to Thompson's Island: salt spray, an unparalleled view of the Boston skyline over water, and a picture-perfect sky. We jostle aboard at the Long Wharf—where do you park in this part of Boston? More chats, friendships freshened. Did you ever know such a group? If not "the greatest concentration of medical talent," certainly a wonderfully friendly, articulate, effusive collection of fascinating experiences and lives lived full to the brim. Life stories are brought up to date and those missing are asked after.

The Bay Tower Room: Sumptuous views—all of Boston spread out in breathtaking gameboard array. Did we really grow up here? More familiar faces arrive. Impression continues to confirm: what an engaging, talented, lively collection of warm people! A rare privilege to have belonged to this group. After dinner Bob Rose, with incredible tolerance, allows us to pelt him as he muses on our mid-life passage; Leonard Sugarman unfolds the plight of the reunion spouse, taking a bit of revenge on us reunion groupies; and Peter Liebert's slides provide a finale that allows us, à la Burns, "to see ourselves as others see us."

—Larry Strasburger '61

25th Reunion

1966

As the burnt orange sun slid into the harbor behind our launch Saturday evening, the Class of 1966 concluded a most memorable 25th reunion week.

The festivities had begun Wednesday evening at a cocktail party generously hosted by Jensie and Bill Shipley. The good feeling carried over to the Thursday Class Day presentations, which had been orchestrated by Charlie Hatem. The wide-ranging talks covered many areas of practice patterns and personal development. Dick Hannah spoke of the rewards and trials of private practice. John Ludden traced the development of the HMO pattern of practice. Several classmates focussed on their personal evolution, with Dave Scharff revealing himself as a reunion biographer and Jim Gordon allowing us to share his personal transformation. Joan Lamb Ulyott recounted her odyssey to a healthy heart.

On a lighter note, Gene Mark recounted the history of the CPC at MGH and Mike Marmor provided perspectives on art and vision. Several classmates gave us insight into their chosen medical field. Bob Fletcher showed us the challenges of medical publishing, while David Dole gave us a clear explication of his work with colony stimulating factor. Ted Pincus demonstrated how educational level related to morbidity and mortality in rheumatoid patients and Barbara McNeil gave her perspective on health care policy. Ned Cassem's approach to the dying patient also raised our level of awareness to the problems of depression.

On Thursday evening, our class dinner featured individual presentations by every member of the class present. The general mood evoked was the mixture of hilarity and warmth that has so marked our class.

Friday's scientific sessions and the gala medical school alumni dinner led smoothly into the culminating clambake on Thompson's Island. On the island long discussions, a vigorous volleyball game and delicious lobster satiated all needs of the reunioning classmates.

And so, onto the sunset cruise home, with the class unanimous in good spirits and the desire to see each other once again.

—Jay H. Kaufman '66

1961

20th Reunion

Anticipating the reunion, I first faced competing claims for my time and attention—another conference, family activities. Did I really have time for a reunion? Beneath that was anxiety about what I would find.

It began for me on Thursday. About 40 people attended the cocktail party at my house. Each time the bell rang there was a moment of confusion. Would I recognize the face? Yet, what I saw in the faces was friendliness. The pleasure in seeing one another and in finding out about one another's lives made the party so much fun I didn't want it to end. It was then I noticed I was hooked on the reunion.

On Friday night many chose more

personal gatherings than the banquet, but for the few of us who attended, the experience was personal in a different way. What emerged was a sense of our class as part of a grand tradition, but also as distinct from the other classes surrounding us. At our table we talked about our work, lives and our families, about education and politics, economics and Shakespeare. Those who had gone to the meetings reported them as interesting, with active participation from those attending, resulting in feelings of acknowledgment as well as discovery.

Saturday at the Donaldson's was a grande finale. Craig and Jennifer created the setting and the wonderful lobster dinner, and the class relaxed. We sat on the grass under a brilliant sky, and children played while their parents talked. Making the rounds, telling stories, hearing stories—exciting research, new ideas in medicine, frustrations about managed care, and impossible medical dilemmas. With some exotic exceptions to make us as a class more interesting, we are all enjoying our work of taking care of patients. The conversation I heard was sometimes intellectual and sometimes questioning, but always thoughtful, appreciative and supportive of one another. Someone said, "I heard our class was an experimental class," and we all understood that he meant we were nice people in contrast with our old, formidable fantasies of HMS. Especially for me, I recovered the warmth and comfort of being in the midst of this particular group of friends, and I felt grateful to all of you for coming—from Washington and Florida, New Hampshire, Maine, Virginia, California, Oregon, New Mexico, Ohio and other places—for helping me find this good piece of my history. See you in five years!

—Alexandra Murray Harrison '71

1976

1971

15th Reunion

A cross section of almost 40 gathered at the Bay Tower Room to commemorate our 15th year reunion. In some instances, we stumbled and had to recognize classmates more by voice than by appearance. Dave Nierenberg told us that the percentage of our classmates contributing to the Alumni Fund has for the first time ever exceeded 55 percent. Alan Pollack, chairman of the reunion committee, and Tom Aretz, treasurer, helped welcome those who traveled from out of town. A large contingent of West Coast classmates flew across the continent for the celebrations, including Bob Bassett, Steve Carney, Wes Curry, Phyllis Gardner, Johnson Lightfoote and Jane Parnes. Successful careers were represented by a newly appointed professor (Laurie Glimcher) and a medical school dean of student affairs (Debbie Campano German). The unlikely trio of Phyllis Gardiner, Jaime Rivera and Sam Goldhaber—who had been assigned to the

same first-year tutorial group in 1972—recounted memories of that very impressionable year. A somber moment of silence memorialized Jack Schiff. To help us recollect the tribulations of HMS clinical rotations, Marvin Bittner recounted in verse and dramatization "The Seven Warning Signals," which was the evening's theatrical highlight.

The next day weather was perfect as we headed to the spectacular home of Hugh Auchincloss and Laurie Glimcher at Manchester by the Sea. We were joined by about 30 children who had not attended the previous night's festivities. In addition to an elegant buffet lunch, we swam in the pool, hit tennis balls by racquet or by bat, and strolled to the ocean. As evening approached, we bid farewell and resolved to keep in closer touch with each other during the next five years.

—Samuel Z. Goldhaber '76

1981

10th Reunion

The Class of 1981 had a pretty good time at their 10th reunion. More than 30 classmates came to the Harvard Faculty Club, most for the first time, for dinner on Thursday evening. Michael Payne's urbane efforts as host were especially appreciated.

Fortunately the weather on Saturday was excellent because more than 70 people showed up for the clambake at the home of Manuel Lowenhaupt. To compensate for receding hairlines and expanding waists were the kids, all of whom will grow up to be lawyers. A good time was had by all, although there was quite a bit of beer left over in the keg.

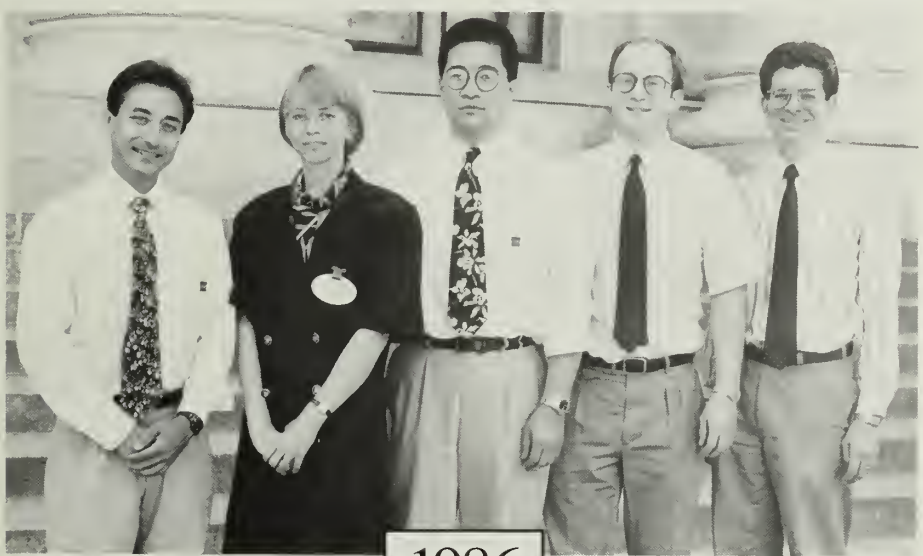
—Manuel T. Lowenhaupt '81

5th Reunion

Forty-two classmates and spouses marked the fifth year reunion of the Class of 1986 with a festive cocktail-dinner reception in the Bartlett Room of the Harvard Club on Thursday night and a well-attended picnic at the Farm in Chestnut Hill on Saturday. The local contingent included John Ayanian, Barb Botelho, Dave Cohen, Jean Elrick, Mark Girard, Chul Soo Ha, Kathy Jenkins, Ken Kaye, Tal Laor, Liz Mort, Marie Pasinski, Scott Phillips, John Puskas, Mike Quinones, Sal Ruggiero, Scott Solomon, Eric Stein, Jennifer Stone, Mike Trice and Frank Voss. In addition, several folks trouped in from distances far and near: Dan Carey from Atlanta, Carolyn Federman from Providence, Pepper Murray from Utah, Holly Smith from St. Paul, and Prentice Tom from Baltimore.

The reunion was a wonderful opportunity to renew old bonds of friendship and catch up on the activities of the past five years. The research productivity as well as the biological reproductivity of the class members were most impressive—potential future HMS alumni/ae included: Katherine Ayanian, Frances Carey, the Quinones children (Jennifer, Lindsey, and Jonathan) and Allison Voss! We thank everyone who took the time and effort to attend and make the reunion such a success. We look forward to another five years of health and happiness for all and truly hope to see an even bigger turnout for the 10th reunion.

—Mark S. Hughes '86



1986

Fellowships for HMS Alumni

1992–93

Fellowships are available for graduates of Harvard Medical School to undertake a year of postgraduate study. The amounts awarded for stipends are determined by the specific needs of the individual: $20,000–$30,000 is the norm.

William O. Moseley, Jr. Traveling Fellowship
Support for a year of postgraduate study in Europe

Warren-Whitman-Richardson
Support for research in the U.S. or abroad

The Committee on Fellowships gives preference to those Harvard Medical School graduates who:

1. Have already demonstrated their ability to make original contributions to knowledge.
2. Have planned a program of study which in the Committee's opinion will contribute significantly to their development as teachers and scholars.
3. Clearly plan to devote themselves to careers in academic medicine and the medical sciences.

The Committee requests that applications be submitted not more than one year in advance of the requested beginning date. The Committee meets once a year in January to review all applications on file by December 31. Applicants will be notified by February 15.

Information and application forms may be obtained from:

Committee on Alumni Fellowships
Harvard Medical School
Room 414, Building A
25 Shattuck Street, Boston MA 02115